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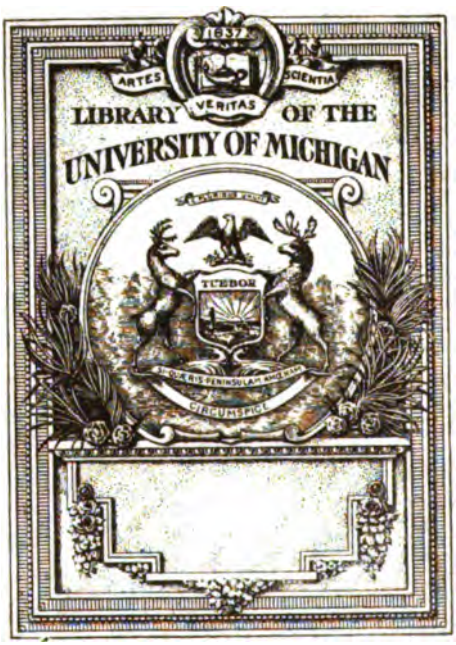

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TRANSACTIONS

OF THE

PATHOLOGICAL SOCIETY OF LONDON.

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VOLUME EIGHTH.

INCLUDING THE REPORT OF THE PROCEEDINGS FOR THE SESSION 1856-7.

LONDON:

PRINTED FOR THE SOCIETY BY J. W. ROCHE, 76, ADAM STREET, ROTHERHITHE.

1857.

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The present publication being the Eighth Volume of Transactions, constitutes the Eleventh published Annual Report of the Pathological Society's proceedings.

The Council think it right to repeat, that the exhibitors are alone responsible for the descriptions given of the Specimens exhibited by them, the only change made in the Reports furnished by the authors being such verbal alterations as were absolutely necessary.

53, Berners Street, Oxford Street,
September, 1857.

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ANDRAL, G., M.D., Professor in the Faculty of Medicine, Paris.

*BENTLEY, EDWARD, M.D., (formerly Honorary Secretary), Physician to the City of London Hospital for Diseases of the Chest, Hackney.

CRAMPTON, SIR PHILIP, Bart., F.R.S., M.R.I.A., Surgeon-General to the Forces in Ireland.

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* Former Members of Council.
† Have paid Life Subscriptions.
‡ Have paid Composition Fee for Transactions.

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Elected Session

**Orig. Memb.* Adams, William, Esq., Assistant Surgeon to the Royal Orthopædic Hospital, 5, Henrietta-street, Cavendish-square.

1847-48 Aikin, Charles A., Esq., 8, Southwick-street.

1851-52 Allchin, William Henry, M.B., 7, Pembridge-villas, Westbourne-grove.

1854-55 Armitage, Thomas Rhodes, M.D., Physician to St. Mary-le-bone General Dispensary, 21, Edward-street, Portman-square.

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1851-52 Ashton, T. J., Esq., Surgeon to the Blenheim-street Dispensary, 31, Cavendish-square.

Orig. Memb. Ashwell, Samuel, M.D., 30, Brook-street.

Orig. Memb. Babington, Benjamin Guy, M.D., F.R.S. (late President), late Physician to Guy's Hospital, 31, George-street, Hanover-square.

1854-55 Babington, C. Metcalf, L.R.C.P., Physician Accoucheur to Queen Charlotte's Lying-in Hospital, 20, Hertford-street, May-fair.

1856-57 Balding, Daniel Barley, Assistant Apothecary and Medical Registrar, Middlesex Hospital.

1849-50 Ballard, Thomas, Esq., 10, Southwick-place, Hyde-park.

1850-51 Baly, William, M.D., F.R.S., (C.), Physician to the Penitentiary, Millbank, and Assistant Physician to St. Bartholomew's Hospital, 45, Queen Anne-street, Cavendish-square.

1851-52 Barclay, A. Whyte, M.D., Assistant Physician to St. George's Hospital, 23A, Bruton-street.

Orig. Memb. Barker, Thomas Herbert, M.D., Priory-terrace, Bedford.

1855-56 Barker, T. A., M.D., Senior Physician to St. Thomas's Hospital, 71, Lower Grosvenor-street.

**Orig. Memb.* Barlow, George Hilaro, M.D., Physician to Guy's Hospital, 5, Union-street, Southwark.

1852-53 Barwell, Richard, Esq., Assistant Surgeon to the Charing Cross Hospital, 22, Old Burlington-street.

1852-53 Bartlett, William, Esq., Surgeon to the Kensington Dispensary, Notting-hill.

1851-52 Beale, Lionel S., M.D., F.R.S., Physician to King's College Hospital, 27, Carey-street, Lincoln's-inn.

1855-56 Bealey, A., M.D., M.A., 27, Tavistock-square.

1852-53 Beck, Thomas S., M.D., F.R.S., Physician to the Farringdon Dispensary, 9A, Langham-place.

*1849-50 Beith, Robert, M.D., Surgeon, Royal Naval Hospital, Deal.

1846-47 Bennet, James Henry, M.D., Physician Accoucheur to the Royal Free Hospital, 60, Grosvenor-street.

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‡1856-57 Bickersteth, E. R., Surgeon, Liverpool Royal Infirmary, 2, Rodney-street, Liverpool.

1848-49 Bird, James, M.D., late Physician-General, Bombay Army, 27, Hyde-park-square.

1855-56 Bird, W., Esq., Brook-green, Hammersmith.

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**Orig. Memb.* Birkett, John, Esq., Surgeon to Guy's Hospital, 59, Green-street, Grosvenor-square.

1853-54 Black, Cornelius, M.B., Physician to the Chesterfield Dispensary, St. Mary's-gate, Chesterfield.

1849-50 Blagden, Robert, Esq., Surgeon to the St. George's and St. James's Dispensary.

1855-56 Borham, W. H., Esq., 19, Cambridge-terrace, Hyde-park.

*1850-51 Bowman, William, Esq., F.R.S., Surgeon to King's College and to the Royal London Ophthalmic Hospitals, 5, Clifford-street.

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*1846-47 Brinton, William, M.D., Senior Physician to the Royal Free Hospital, 20, Brook-street.

1856-57 Briscoe, John, Esq., House Surgeon and Apothecary, Radcliffe Infirmary, Oxford.

†1850-51 Bristowe, J. S., M.D., (C.), Assistant Physician to, and Demonstrator of Morbid Anatomy at, St. Thomas's Hospital, 3, St. Thomas's-street, Borough.

1851-52 Brodhurst, Bernard, Esq., Assistant Surgeon to the Royal Orthopædic Hospital, 14, Brook street.

*1846-47 Brooke, Charles, M.B., F.R.S., Surgeon to Westminster Hospital, 29, Keppell-street, Russell-square.

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1855-56 Bryant, T., Esq., Assistant Surgeon to Guy's Hospital, 40, Wellington-street, London-bridge.

1854-55 Buchanan, George, M.D., Resident Medical Officer, London Fever Hospital.

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*1856-57 Buzzard, Thomas, Esq., 41, Great Marlborough-street.

1856-57 Callender, George William, Registrar and Demonstrator of Anatomy at St. Bartholomew's Hospital, Surgeon to the North London Eye Infirmary, 35, Queen Anne-street, Cavendish-square.

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1854-55 Carpenter, Alfred, Esq., High-street, Croydon.

1848-49 Carpenter, William Guest, Esq., Surgeon to the City of London Dispensary, 1, West-street, Finsbury-circus.

1855-56 Carter, H. V., Esq., St. George's Hospital.

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1851-52 Childs, George Borlase, Esq., Surgeon to the Metropolitan Free Hospital, and to the City Police Force, 11, Finsbury-place South.

1854-55 Cholmeley, William, M.D., Physician to the West London Dispensary, 40, Russell-square.

1851-52 Chowne, William D., M.D., Physician to the Charing Cross Hospital, 8, Connaught-place West, Hyde-park.

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1855-56 Clarke, J. F., Esq., Senior Surgeon to the Dorcas Charity, 23, Gerrard-street, Soho.

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1854-55 Daubeney, Henry, M.D., 34A, York-street, Portman-square.

*1846-47 Davis, John Hall, M.D., Physician to the Royal Maternity Charity, and to the St. George's and St. James's Dispensary, 11, Harley-street, Cavendish-square.

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1851-52 Devenish, Samuel Weston, M.B., 7, Billiter-square.

1855-56 Dick, H., M.D., 59, Wimpole-street.

**Orig. Memb.* Dixon, James, Esq., Surgeon to the Royal London Ophthalmic Hospital, 1, Portman-square.

1855-56 Druitt, R., M.D., Officer of Health, St. George's, Hanover Square, 39A, Curzon-street, May-fair.

1851-52 Drury, James Samuel, M.D., 44, Albion-street, Hyde-park.

1846-47 Dudgeon, Robert E., M.D., 82, Gloucester-place, Portman-square.

1851-52 Duff, George, M.D.

1848-49 Eden, Thomas E., Esq., Surgeon Dentist to the Farringdon General Dispensary, 45, Threadneedle-street.

1854-55 Edwards, George N., M.D., Assistant Physician to the City of London Hospital for Diseases of the Chest, 8, Finsbury-pavement.

1846-47 Ellis, Joseph, Esq., Sudbrook-park, Richmond, Surrey.

1851-52 Ely, George Ebenezer, M.D., Rochester.

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*1846-47 Fincham, George T., M.D., Physician to the Westminster Hospital, 28, Chapel-street, Belgrave-square

1853-54 Fisher, W. Webster, M.D., Downing Professor of Medicine, Cambridge.

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1855-56 Gamgee, Joseph Sampson, 16, Upper Woburn-place.

1855-56 Gamgee, J., Esq., Woburn-place.

1850-51 Garrett, Mark Brown, Esq., 3 New Road, St. George's East.

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1846-47 Gream, George T., M.D., 2, Upper-Brook-street.

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‡1854-55 Greenhill, William Alexander, M.D., Physician to the Hastings Infirmary, Carlisle-parade, Hastings.

*1849-50 Habershon, Samuel O., M.D., Assistant Physician to Guy's Hospital, Wimpole-street.

1851-52 Hacon, E. Dennis, Esq., Mare-street, Hackney.

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1855-56 Harley, George, M.D., Teacher of Practical Physiology at University College, 40, Somerset-street, Portman-square.

**Orig. Memb.* Hawkins, Cæsar H., Esq., F.R.S., (late President), Surgeon to St. George's Hospital, 26, Grosvenor-street.

1851-52 Hawkins, Charles, Esq., 22, Saville-row, Consulting Surgeon to Queen Charlotte's Hospital.

1856-57 Hawksley, Thos., M.D., L.R.C.P., Physician to the Dispensary for Consumption, 26, George-street, Hanover-square.

1856-57 Heath, Christopher, Demonstrator of Anatomy at the Westminster Hospital, 28, Gordon-square.

1848-49 Henry, Mitchell, Esq., (Honorary Secretary), Assistant Surgeon to the Middlesex Hospital, and Surgeon to the North London Eye Infirmary, 5, Harley-street.

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1854-55 Hewitt, Graily, M.D., Physician to the Western General Dispensary, and Assistant Physician to the Samaritan Free Hospital for Women and Children, 17, Radnor-place, Hyde-park.

1854-55 Hillier, Thomas, M.D., Officer of Health, St. Pancras, Gower-street, Bedford-square.

Orig. Memb. Hillman, William Augustus, Esq. (C.), Senior Assistant Surgeon to the Westminster Hospital, 1, Argyll-street, Regent-street.

**Orig. Memb.* Hilton, John, Esq., F.R.S., Surgeon to Guy's Hospital, 10, New Broad-street.

1855-56 Hinton, J., Esq., 37, Charterhouse-square,

1852-53 Hogg, Jabez, Esq., Assistant Surgeon to the Westminster Ophthalmic Hospital, 6, Gower-street.

1846 47 Holman, H. Martin, M.D., Hurstpierpoint, Sussex.

1854-55 Holmes, Timothy, Esq., Surgeon to the North London Ophthalmic Hospital, Curzon-street.

*1849-50 Holt, Barnard, Esq., Surgeon to the Westminster Hospital, 5, Parliament-street.

*1850-51 Hodgson, Joseph, Esq., F.R.S., 60, Westbourne-terrace.

1853-54 Hood, William Charles, M.D., Resident Physician, Bethlem Hospital.

1850-51 Hore, Henry A., Esq., House Surgeon, Bristol Infirmary.

1855-56 Hudson, John, M.D., 11, Cork-street.

1854-55 Hulke, John William, Esq., Assistant Surgeon to King's College Hospital.

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1852-53 Humby, Edwin, Esq., 1, Windsor-terrace, Maida-hill.

1852-53 Hutchinson, Jonathan, jun., Esq. (C.), Surgeon to the Metropolitan Free Hospital, 14, Finsbury-circus.

‡1856-57 Jackson, Henry, Senior Surgeon to the Sheffield Infirmary, St. James's Row, Sheffield.

‡1853-54 Jardine, J. L., Esq., Brixton-hill, Surrey.

1846-47 Jay, Edward, Esq., 51, Park-street, Grosvenor-square.

**Orig. Memb.* Jeaffreson, Henry, M.D., (V.P.), Physician to St. Bartholomew's Hospital, and Consulting Physician to the City of London Hospital for Diseases of the Chest, 2, Finsbury-square.

**Orig. Memb.* Jenner, William, M.D., Physician to the Hospital for Sick Children, and to University College Hospital, 8, Harley-street.

1854-55 Johnson, Athol A. W., Surgeon to the Hospital for Sick Children, 37, Albemarle-street.

1854-55 Johnson, Edward, M.D., 211, Regent-street.

**Orig. Memb.* Johnson, George, M.D., Physician to King's College Hospital, and to the Bishop's Court Dispensary, 3, Woburn-square.

*1846-47 Johnson, Henry Charles, Esq., Surgeon to St. George's Hospital, 6, Saville-row.

1856-57 Johnstone, J. S., M.D., 39, Devonshire-street, Portland-place.

*†*Orig. Memb.* Jones, Henry Bence, M.D., F.R.S., (V.P.), Physician to St. George's Hospital, 30, Grosvenor-street.

1853-54 Jones, Sydney, M.B., 4, St. Thomas's-street, Lecturer on Comparative Anatomy, and Demonstrator of Morbid Anatomy at St. Thomas's Hospital.

1856-57 Jones, George Matthew, Surgeon to the General Hospital, Old-street, St. Heliers, Jersey.

1846-47 Kent, Thomas J., Esq., 30, Queen Ann-street, Cavendish-square.

1852-53 Kershaw, W. Wayland, Esq., Kingston-on-Thames.

1854-55 Kirkes, William Senhouse, M.D., Assistant Physician to St. Bartholomew's Hospital, 2, Lower Seymour-street.

1854-55 Kirby, Edmund A., Esq., 32, Euston-square.

1851-52 Kingdon, J. Abernethy, Esq., Surgeon to the City Dispensary, 2, New Bank-buildings.

1856-57 Kingsley, Henry, M.D., Physician to the Stratford Infirmary, Stratford-on-Avon.

1850-51 Langmore, J. Charles, M.B., Surgeon to the Paddington Dispensary, 20, Oxford-terrace.

*1849-50 Latham, Peter Mere, M.D. (late President), 36, Grosvenor-street.

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Elected Session

1856-57 Laurence, J. Z., Surgeon to the Northern Dispensary, 30, Devonshire-street, Portland Place.

1853-54 Lawrence, Henry John Hughes, Esq., Assistant Surgeon, Coldstream Guards.

1851-52 Lee, Henry, Esq., Surgeon to King's College and the Lock Hospitals, 9, Saville-row.

1852-53 Leggatt, Alfred, Esq., Surgeon to the Chelsea Dispensary, 13, William-street, Lowndes-square.

*1849-50 Liddell, Sir John, C.B., M.D., F.R.S., Director General of Naval Hospitals and Fleets.

*1848-49 Little, William John, M.D., (V.P.), Physician to the London Hospital, 34, Brook-street.

**Orig. Memb.* Lloyd, Edward, M.D., Physician to the Royal General Dispensary, 4, Suffolk-place, Pall-mall.

1852-53 Lloyd, Eusebius A., Esq., Surgeon to St. Bartholomew's Hospital, 14, Bedford-row.

1855-56 Macann, A., Esq., 22, King-street, Portman-square.

1851-52 Mackenzie, Frederick William, M.D., Physician to the Paddington Dispensary for the Diseases of Women, &c., 11, Chester-place, Hyde-park-square.

1853-54 Macmurdo, Gilbert, Esq., F.R.S., Surgeon to St. Thomas's Hospital, New Broad-street.

1851-52 Markham, William O., M.D., Assistant Physician to St. Mary's Hospital, 33, Clarges-street.

1846-47 Marshall, John, Esq., Assistant Surgeon to University College Hospital, 10, Saville-row.

1856-57 Martin, Robert, M.B., Assistant Physician to St. Bartholomew's Hospital; The College, St. Bartholomew's Hospital.

1852-53 Martyn, S., M.D., Physician to the Bristol General Hospital, 44, St. Michael's-hill, Bristol.

1851-52 May, George, M.B., Reading.

1854-55 Miles, Charles, Esq., 13, Conduit-street West, Hyde-park.

1846-47 Morgan, John, Esq., (C.), 5, Albion-place, Hyde-park-square.

1852-53 Moseley, George, Esq., Surgeon to the Dispensary, Sandgate.

1854-55 Murchison, Charles, M.D., Assistant Physician to King's College and to the London Fever Hospitals, Sackville-street.

1855-56 Nasmyth, Robert, M.D., 49, Brook-street.

1856-57 Nunn, Thomas William, Surgeon to the St. Marylebone General Dispensary, and Lecturer on Pathology, Middlesex Hospital, 8, Stratford-place, Oxford-street.

1850-51 Obré, Henry, Esq., (C.), 1, Melcombe-place, Dorset-square.

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1852-53 O'Connor, William, M.D., Physician to the Royal Free Hospital, 30, Upper Montagu-street, Montagu-square.

1852-53 Ogle, James Adely, M.D., Regius Professor of Medicine, Oxford.

1850-51 Ogle, John W., M.B., (Hon. Secretary) Assistant Physician to St. George's Hospital, and Pathological Curator to St. George's Hospital Museum, 13, Upper Brook-street.

1853-54 Ogle, William, L.R.C.P., Physician to the Royal Pimlico Dispensary, Chester-terrace, Eaton-square.

‡1855-56 Oldfield, Edmund, Esq., Boscomb Lodge, Finchley-road.

1854-55 Panton, P., M.D., 20, Gloucester-terrace.

1853-54 Parkinson, George, Esq., 11, Grosvenor-street.

1853-54 Part, James, Esq., 7, Camden-road-villas, Camden-town.

**Orig. Memb.* Partridge, Richard, Esq., F.R.S., (late V.P.), Surgeon to King's College Hospital, 17, New-street, Spring Gardens.

**Orig. Memb.* Peacock, Thomas Bevill, M.D., (late V.P. and Hon. Secretary), Assistant Physician to St. Thomas's Hospital, and Physician to the City of London Hospital for Diseases of the Chest, 20, Finsbury-circus.

**Orig. Memb.* Poland, Alfred, Esq., Assistant Surgeon to Guy's, and Surgeon to the Royal London Ophthalmic Hospitals, 10, Bolton-row, Curzon-street, May-fair.

*1846-47 Pollock, George, Esq. (late Honorary Secretary), Assistant Surgeon to St. George's Hospital, 27, Grosvenor-street.

1850-51 Pollock, James Edward, M.D., Assistant Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, 4, Chandos-street, Cavendish-square.

1854-55 Potts, William, Esq., 12, North Audley-street.

1856-57 Price, Peter Charles, Surgeon, Blenheim-street Dispensary, 7, Green-street, Grosvenor-square.

1856-57 Priestley, William Overend, M.D., Accoucheur to the St. George's and St. James's Dispensary, 16, Somerset-street, Portman-square.

†1848-49 Purnell, John James, Esq., 4, Melbourn-place, Acre-lane, Brixton.

1850-51 Pyle, John, Esq., Surgeon to the North London Eye Infirmary, 56, Oxford-terrace, Hyde-park-square.

**Orig. Memb.* Quain, Richard, M.D., (Treasurer, late Hon. Secretary), Physician to the Hospital for Consumption and Diseases of the Chest at Brompton, 23, Harley-street, Cavendish-square.

1855-56 Rae, J., Esq., Surgeon, R.N., Greenwich Hospital.

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Orig. Memb. Ramsbotham, Francis H., M.D., (late V.P.), Physician Accoucheur to the London Hospital, 7, Portman-square.

1856-57 Ramskill, J. S., M.D., Physician, Metropolitan Free Hospital, 5, St. Helen's-place.

1847-48 Randall, John, M.D., 14, Portman-street, Portman-square.

1856-57 Rantre, Henry, M.D., 21, Fitzroy-square.

1846-47 Ray, Edward Esq., Dulwich.

1852-53 Rees, George Augustus, M.D., Medical Officer, General Dispensary for Children, 45, Finsbury-square.

1854-55 Reynolds, J. Russell, M.D., Assistant Physician to the Westminster Hospital, 38, Grosvenor-street.

Orig. Memb. Ridge, Joseph, M.D., 39, Dorset-square.

1856-57 Richardson, Benjamin Ward, M.D., Physician to the Infirmary for Asthma, 12, Hinde-street, Manchester-square.

Orig. Memb. Roe, Hamilton George, M.D., Physician to the Hospital for Consumption and Diseases of the Chest, at Brompton, 57, Park-street.

1855-56 Roberts, John Henry, Esq., 10, Finchley-road.

1856-57 Robinson, Thomas, 50, Southampton-street, Pentonville.

1855-56 Rogers, G. Goddard, Medical Registrar, St. George's Hospital, 9, Allen Terrace, Kensington.

1851-52 Rook, H. T., M.D., Assistant Surgeon to the Hospital-ship "Dreadnought."

1852-53 Salter, Henry Hyde, M.D., F.R.S., Assistant Physician to Charing-cross Hospital, 6, Montague-street, Russell-square.

1853-54 Salter, Samuel James A., M.B., F.L.S., 17, New Broad-street.

1852-53 Sanderson, Hugh James, Esq., Surgeon to Hospital for Women, 26, Upper Berkeley-street.

1854-55 Sanderson, John S. B., M.D., Physician to the Western General Dispensary, 9, Gloucester-place, Hyde-park.

*1846-47 Sankey, W. H. O., M.B., Hanwell Lunatic Asylum.

Orig. Memb. Scott, John, M.D., (V.P.) 13, Stratton-street.

1853-54 Scott, John, Esq., Surgeon to the Hospital for Women, Soho-square, 65, Harley-street.

1846-47 Seaton, Edward C., Surgeon to the Chelsea, Brompton, &c., Dispensary, 33, Sloane-street, Knightsbridge.

1856-57 Sedgwick, William, Surgeon to the St. Mary-le-bone Provident Dispensary, 12, Park-place Upper Baker-street.

1852-53 Semple, Robert Hunter, M.D., Physician to the Northern Dispensary, 8, Torrington-square.

Orig. Memb. Shaw, Alexander, Esq., (late Treasurer), Surgeon to the Middlesex Hospital, 25, Henrietta-street, Cavendish-square.

1856-57 Shillito, Buxton, 34, Finsbury-circus.

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1855-56 Sibley, Septimus W., Esq., Medical Registrar to the Middlesex Hospital, 14, New Burlington-street.

1848-49 Sibson, Francis, M.D., F.R.S., (C.), Physician to St. Mary's Hospital, 43, Brook-street.

1847-48 Sieveking, Edward, H., M.D., (C.), Physician to St. Mary's Hospital, 3, Bentinck-street, Manchester-square.

1850-51 Simmonds, James B., Esq., Professor, Royal Veterinary College.

**Orig. Memb.* Simon, John, Esq., F.R.S., (V.P.), Surgeon to St. Thomas's Hospital, 1, Cumberland-street, Hyde-park.

**Orig. Memb.* Smith, Ebenezer Pye, Esq., 7, Billiter-square.

1854-55 Smith, Edward, M.D., Assistant Physician to the Hospital for Consumption and Diseases of the Chest, at Brompton, 63, Grosvenor-street.

1846-47 Smith, Protheroe, M.D., Physician to the Hospital for Women, 21, Park-street, Grosvenor-square.

1851-52 Smith, W. Tyler, M.D., Physician Accoucheur to St. Mary's Hospital, 7, Upper Grosvenor-street.

1855-56 Smith, H. Spencer, Esq., Surgeon to St. Mary's Hospital, 48, Sussex-gardens, Hyde-park.

1856-57 Smith, Thomas, Esq., St. Bartholomew's Hospital.

1850-51 Snow, John, M.D., 18, Sackville-street.

1854-55 Squire, William, Esq., 6, Orchard-street, Portman-square.

*1847-48 Solly, Samuel, Esq., F.R.S., Surgeon to St. Thomas's Hospital, 18, St. Helen's-place.

*1850-51 Stanley, Edward, Esq., F.R.S., Surgeon to St. Bartholomew's Hospital, 23A, Brook-street.

1856-57 Stevens, Henry H., Esq., Surgeon, Islington Dispensary, 2, Finsbury-place South.

1854-55 Stewart, William Edward, Esq., Surgeon to St. Marylebone Provident Dispensary, 8, Weymouth-street, Portland-place.

†1853-54 Streatfield, J. F., Esq., Assistant Surgeon Moorfields Eye Infirmary, 1, Finsbury-square.

†1850-51 Sutherland, Alexander John, M.D., F.R.S., Physician to St. Luke's Hospital, Richmond-terrace, Whitehall.

‡1856-57 Symonds, Frederick, Esq., Surgeon, Radcliffe Infirmary, 32, Beaumont-street, Oxford.

Orig. Memb. Tamplin, R. W., Esq., Surgeon to the Royal Orthopædic Hospital, 33, Old Burlington-street.

‡1855-56 Tapp, W. Denning, Esq., Surgeon to the Dorset County Hospital, Dorchester.

1850-51 Tatum, Thomas, Esq., Surgeon to St. George's Hospital, 3, George-street, Hanover-square.

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1851-52 Taylor, Robert, Esq., Surgeon to the Central London Eye Infirmary, 10, George-street, Hanover-square.

1848-49 Tebay, Thomas G., Esq., 1, Little Smith-street, Westminster.

1852-53 Thompson, Henry, Esq., Surgeon to the Marylebone Infirmary, and Assistant Surgeon to University College Hospital, 16, Wimpole-street.

1851-52 Thompson, Theophilus, M.D., F.R.S., (C.), Physician to the Hospital for Consumption and Diseases of the Chest, at Brompton, 3, Bedford-square.

1851-52 Todd, Robert Bentley, M.D., F.R.S., Physician to King's College Hospital, 26, Brook-street.

1856-57 Tomes, J., Esq., F.R.S., Surgeon Dentist to the Middlesex Hospital, 37, Cavendish-square.

**Orig. Memb.* Toynbee, Joseph, Esq., F.R.S., Surgeon Aurist to St. Mary's Hospital, 18, Savile Row.

1851-52 Trotter, John William, Esq., Assistant Surgeon, Coldstream Guards.

1847-48 Tuke, T. Harrington, M.D., (C.), Manor-house, Chiswick.

1852-53 Tulloch, James S., M.D., 16, Chepstow-villas West.

1856-57 Tyrrell, Walter, Esq., Surgeon to the National Truss Society, 1, St. Helen's-place, City.

1853-54 Van der Byl, Philip, M.D., Physician to the Northern Dispensary, 1, Oxford-square.

1854-55 Vasy, Charles, Esq., 5, New Bond-street.

1856-57 Valpy, W. H., Esq., 9, Bedford-street.

1856-57 Vernon, Henry Hannotte, M.D., 18, Cambridge-terrace, Hyde-park.

1850-51 Wagstaff, W. R., M.D.

Orig. Memb. Waite, Charles D., M.D., Physician to the Western General Dispensary, 2, Old Burlington-street.

1851-52 Walker, J. Butterworth, Esq., 8, Hamilton-place, St. John's-wood.

Orig. Memb. Walton, Henry Haynes, Esq., (C.), Surgeon to the Central London Ophthalmic Hospital, and Surgeon to St. Mary's Hospital, 69, Brook-street.

‡*Orig. Memb.* Ward, Joseph, Esq., Epsom, Surrey.

**Orig. Memb.* Ward, Nathaniel, Esq., (formerly Honorary Secretary), Assistant Surgeon to the London Hospital, 1, Broad-street-buildings.

*1846-47 Ward, T. Ogier, M.D., Surgeon to the Kensington Dispensary, 9, Leonard-place, Kensington.

**Orig. Memb.* Ware, James T., Esq., Surgeon to the Finsbury Dispensary, 51, Russell-square.

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1855-56 Watson, Thomas, M.D., (President), Consulting Physician to King's College Hospital, 16, Henrietta-street, Cavendish-square.

1854-55 Webb, Francis Cornelius, M.D., 39, Great Coram-street.

1851-52 Welch, Henry James, Esq., 1, Dalston-terrace.

1853-54 Wells, Thomas Spencer, Esq., Surgeon to the Samaritan Free Hospital for Women, 3, Upper Grosvenor-street.

1850-51 West, Charles, M.D., (C.), Physician Accoucheur to St. Bartholomew's Hospital, and Physician to the Hospital for Sick Children, 96, Wimpole-street.

1854-55 Wilks, Samuel, M.D., (C.), Assistant Physician and Demonstrator of Morbid Anatomy at Guy's Hospital, 17, St. Thomas's-street, Southwark.

1856-57 Wilkin, H. C., 39, Connaught-terrace, Hyde-park.

**Orig. Memb.* Williams, C. J. B., M.D., F.R.S., (formerly President), Consulting Physician to the Hospital for Consumption and Diseases of the Chest, at Brompton, 49, Upper Brook-street.

1850-51 Wood, John, Esq., (C.), Assistant Surgeon to King's College Hospital, King's College, Strand.

1854-55 Wood, Barnes, M.D., Gloucester-place.

1854-55 Wood, William, M.D., 54, Upper Harley Street, and Kensington House, Kensington.

1853-54 Wordsworth, John C., Esq., Assistant Surgeon to the London and to the Royal London Ophthalmic Hospitals, 41, Finsbury-square.

1852-53 Wright, Edward, Esq., Montague-place, Clapham-road.

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REPORT.

SESSION 1857-58.

I.—DISEASES, ETC., OF THE NERVOUS SYSTEM.

1. *Case of Fatty Degeneration of the Voluntary Muscles. Softening of the Spinal Cord.*

C. M. was born at St. Albans on the 1st of December, 1838, of healthy parents, in comfortable circumstances. In 1840 he was removed to London, and since 1842 resided in airy parts of Brompton and Chelsea. Up to the summer of 1845 he was a strong, active boy, but then had, in quick succession, jaundice, measles, and remittent fever. The latter was severe and of several weeks duration, was accompanied by drowsiness and slight delirium, and complicated with ascites. He slowly recovered his health; but never entirely regained the strength of his lower extremities. He was observed frequently to fall when walking, and was soon fatigued by exercise; he had a good deal of difficulty, also, in getting up stairs. The muscles of his thighs and legs were large, and those of the calf remarkably firm.

In 1847 he was seen by Sir Benjamin Brodie, and again in 1848; he then walked with much greater difficulty, and his gait was most peculiar; he stepped only on his toes, threw his shoulders back, and his abdomen prominently forwards; he had also very great difficulty in raising himself from a sitting posture on the floor; his health was at this time perfectly good, and he had no other symptom than the weakness of his lower extremities. His case was supposed to be one of spinal disease, and was treated with iodine, internally and externally, tonics, change of air, generous diet, &c.

Incontinence of urine came on in the autumn of 1848, and increased considerably under the use of galvanism, which was

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tried in November and December. This symptom lasted about a year, and then entirely left him. In 1850 the upper extremities began to suffer, and by this time Sir B. Brodie had become acquainted with the results of the *post-mortem* examination of a case, in which the symptoms had been precisely similar, but where the nervous centres had been found, on dissection, to be quite healthy, and the only morbid appearance was fatty degeneration of the voluntary muscles.* Sir Benjamin now considered our patient to be suffering from this affection, and gave up the idea of spinal disease.

In 1851 the boy had entirely lost the power of walking, but managed to crawl about the house on his hands and knees; the muscles of the lower extremities were by this time much wasted, and the arms had begun to suffer in the same way.

By 1854 he was unable any longer to crawl; his arms had become so feeble that he could not help himself in any way, or lift a plate from the dinner table.

In 1855 he had a sharp attack of bronchitis, but recovered perfectly.

In 1856 his health still continued excellent, but the feebleness of the upper extremities had so much increased that he could not lift either hand from the table at which he was sitting; he was still able, notwithstanding, to write a very tolerable hand; he could sit erect for many hours when placed in that position.

The sensibility of the skin was never for a moment impaired. There was an entire absence of all pain, cramp, or twitching in the affected muscles; he had always perfect command of the rectum and bladder, except during those parts of the years 1848 and 1849, when he suffered from incontinence of urine; articulation and deglutition were perfect; his functions were all well performed, and for some years he had taken but little medicine; the sounds and impulse of the heart were normal, and his pulse was of average strength; his mind was clear, and he was fond of reading and composition, especially of writing poetry; and

* *Vide* Dr. E. Meryon's paper "On Granular and Fatty Degeneration of the Voluntary Muscles," in the Med.-Chirurg. Transactions for 1852. This paper contains the first account of the disease published in this country.

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for the last two or three years of his life he was of a remarkably happy and amiable disposition, and quite unlike an invalid.

In October, 1856, he was carried off by an attack of pneumonia, after an illness of six days, having been under the writer's observation from the year 1840 to the time of his death.

Mr. Gray, of St. George's Hospital, kindly undertook to make the *post-mortem* examination. The following are the appearances which we noted on that occasion:—

Post-mortem examination, twenty-eight hours after death.—External appearance of head and face, natural. Chest very much flattened; broad in transverse diameter. Arms very much attenuated. Lower limbs very much attenuated and distorted. Knees fixed in a bent position. Feet extended on the legs, and fixed in that position; the dorsum of each foot covered with a thick fleshy cushion, on which he had been accustomed to crawl. Muscles of spine in neck and dorsal regions healthy. The erector spinæ, at its lower part, presented a greyish appearance. Spinal cord.—Internal surface of the dura mater more vascular than usual, particularly in the middle and upper portions, where it corresponded with the softened cord. Cord healthy in its lower third; distinctly softened for six inches above the point of junction of its middle with the lower third. Upper portion healthy. The softening greatest at the middle portion of the affected part, gradually decreases as it approaches the healthy structures of the cord. Roots of spinal nerves normal. Brain.—In both hemispheres the white substance is softer than natural. Muscles.—Muscles of neck rather pale. Pectoralis major, a mere thin lamina, pale. Intercostals thin, but a good colour. Abdominal muscles pale, but tolerably thick. Muscles of thigh, pale. Diaphragm muscle very pale. Chest.—Lower lobe of right lung inflamed, softened, breaks up; lower lobe of left congested; upper lobes of both emphysematous; heart apparently healthy. Abdomen.—General peritoneal adhesion (old); liver congested, otherwise healthy; spleen healthy; kidneys healthy; stomach healthy. Mr. Gray has also shown and communicated to me the results of the microscopical examination.

Microscopical examination.—The cord was free from all appearances of inflammation or fatty degeneration. The muscles of the

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thigh, back, arm, neck and diaphragm, were in various stages of granular and fatty degeneration. Some fibres appeared to have lost their proper sarcous element, while the sarcolemma remained without any adventitious deposit. The walls of the ventricles of the heart, though looking tolerably healthy to the naked eye, were in a state of incipient fatty degeneration. Some fibres had partly lost their striated appearance, and contained a granular deposit within the sarcolemma.

Dr. Richard Quain also examined some of the muscles, and kindly informed me that he had never seen a more perfect specimen of the fatty degeneration of voluntary muscle in its various stages.

It becomes a matter of interest to determine whether the softening of the cord, which was a somewhat unexpected occurrence, was the primary lesion in the case, or an accidental complication only, of recent origin. The following considerations appear to favour the latter view:—

1. The history and symptoms were very unlike those of paraplegia, but closely resembled those of several other cases presently to be noticed, in which the cord was found, upon examination after death, to be perfectly healthy.

2. There were no appearances of inflammation or degeneration in the cord.

3. The diaphragm and heart were in a state of fatty degeneration.

I have collected the records of seven other *post-mortem* examinations, in six of which the muscles were found to be in a state of fatty degeneration or atrophy. The symptoms, during life, more or less resembled those of the case above narrated, and were supposed by the writers to indicate the existence of the same disease.

The results, as far as they concern the nervous system, may be stated as follows:—

* Dr. Richard Quain, in a note to his valuable paper "On Fatty Degeneration of the Heart," in the Transactions of the Med.-Chirurg. Society for 1850, alludes to four instances of Fatty Degeneration of the Voluntary Muscles, and among them to that of a sheep, narrated by Dr. Vaughan, in a little work published in 1813. On turning to this volume, it will be found that the muscles of the legs and loin were entirely converted into a fatty substance, and that the animal did not show any symptoms of muscular weakness till a fortnight before it was slaughtered. The spinal cord was not examined.

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No. of Case.	BRAIN.		SPINAL CORD.		ROOTS OF SPINAL NERVES.
	Healthy.	Diseased.	Healthy.	Diseased.	
No. 1[a]	Substance of the brain healthy.	Plate of bone in arachnoid corresponding to squamous portion of temporal bone. Arachnoid opaque and thickened at same part.	Healthy		Not examined.
2[b]	Healthy.		Healthy.		Not examined.
3[c]	Healthy.		Healthy.		Not examined.
4[d]	Healthy.		Healthy.		Not examined.
5[e]	Healthy.		Healthy.		Anterior roots greatly atrophied; posterior normal.
6[f]	Healthy.		Healthy.		Anterior roots greatly atrophied; posterior normal.
7[g]	Healthy.			Cord softened in lower part of cervical and upper part of dorsal region. One hundred white fibrous bodies varying in size from a pin's head to a small pea, scattered over dorsal surface of cord. Membranes opaque and thickened; inflamed. Numerous granular corpuscles in softened cord.	Anterior roots vascular, softened, and greatly atrophied; some fibres in state of fatty degeneration; posterior normal.
8[h]		White substance of brain softer than usual; otherwise healthy.		Softened; but no indications of inflammation or degeneration.	Anterior and posterior roots normal.

[a] Mr. Partridge's case in "Transactions of Pathological Society," 1847.
[b] Dr. Meryon's case in "Transactions of Med.-Chirurgical Society, 1852.
[c, d, e, f] M. Cruveilhier's cases in his paper "Sur la Paralysie Musculaire Progressive Atrophique," in the Archives Générales de Médicine for May, 1853, and January, 1856. In case 3 the muscles were not examined. In case 6 the muscles were converted into a whitish mass, with a pink tinge; but no traces of fatty degeneration could be found in them.
[g] Dr. J. Valentiner's case. See Dr. Sieveking's Report on Pathology, in Brit. and Foreign Medico-Chirurgical Review for October, 1855.
[h] The case of C. M. above detailed.

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The first six cases of this table show that the state of the voluntary muscles, above described, is quite compatible with a perfectly healthy condition of the spinal cord. The seventh exhibits it in connection with inflammation and softening of that organ; but the case appears to me to have been one of a doubtful nature. M. Aran * has published eight cases of a partial development of this affection in the muscles of one or both upper extremities.

Several of a similar nature have also appeared in other periodicals. Five were collected by Dr. Moore.† In four of these the muscles on one side of the face only were affected; and in the fifth those of the upper extremity.

Another, confined to one of the upper extremities occurred in the practice of Dr. Brunniche, in Frederick's Royal Hospital at Copenhagen.‡

These partial cases appear to be identical in their nature with those of a more general character, and have, in some instances, shown a disposition to spread to the lower extremities, and to involve the whole muscular system. They certainly would not lead us to search for their origin in disease of the spinal cord. The six *post-mortem* examinations already pointed out, wherein that organ was found to be perfectly healthy, also teach us that we must look elsewhere for the true pathology of this affection. M. Cruveilhier§ regards his cases as a species of paralysis depending on atrophy of the anterior roots of the spinal nerves, and looks upon the degeneration of the muscles as a secondary consequence only, and not as a primary lesion. He founds this opinion on the results of the two dissections given in the table (cases 5 and 6), in which the anterior roots in the cervical region were so completely atrophied as to be entirely destitute of their proper nervous element, and to bear a proportion to the posterior of only one to ten, whereas in the normal state they are as one to three. He states, however, that in cases of paraplegia he has found both anterior and posterior roots greatly atrophied. Dr.

* "Archives Generales de Medicine," 1850. This paper contains the first distinct account of the disease with which I am acquainted.

† "Dublin Quarterly Journal," 1852, vol. xiv.

‡ "Brit. and Foreign Med.-Chirurgical Review," 1856, vol. xviii.

§ Loco citato.

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Abercrombie* also refers to two interesting cases of paralysis from disease of the spinal cord. In the first, that in which the upper extremities alone were affected, and the sensibility of the skin was not altered, the anterior roots in the cervical region were completely atrophied, while the posterior retained their nervous matter. In the second, that in which both upper and lower extremities were affected with hyperæsthesia of the skin, the anterior roots were atrophied, but the posterior were hypertrophied. In the cases of paraplegia, and in those of Dr. Abercrombie, as well as in No. 7 in the table, the atrophy of the anterior roots appears to have been the result of the disease of the cord, and the consequent disease of the paralysed muscles. In his own cases, also, M. Cruveilhier has been unable to show that the atrophy of the roots of the nerves preceded the muscular degeneration. It will be seen also in the details of the *post-mortem* examination given above (No. 8 in the table) that the anterior roots were normal, so that we must not, without hesitation, accept M. Cruveilhier's explanation, as it is possible that what he considers the cause of paralysis, may be merely the effect of the disease of the atrophied and degenerate muscles. I am disposed to adopt the views of M. Aran, Dr. Meryon, and others, who regard the disease as one of primary mal-nutrition of the muscular system, rather than to consider it as a paralysis depending either on disease of the cord, or upon atrophy of the anterior roots of the spinal nerves.†

The cases brought forward in Dr. Meryon's paper before alluded to, as well as some others to be presently mentioned, appear to attach something of an hereditary character to this disease, or at least to show a great predisposition to it in certain families. Of Dr. Meryon's cases, four brothers, all the males of a family were afflicted in one instance, two in another, and three in a third. In one of M. Aran's cases of general atrophy and degeneration, the patient had lost a sister and two maternal uncles of the complaint. And in the discussion which followed a paper on this subject, which I lately read before the Western

* On the Brain, 3rd edit., Edinburgh, 1836, p. 350.

† The trunks of the nerves supplying the affected limbs in several of the cases given in the foregoing table, were found to be in a normal condition.

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Medical Society of London, Mr. Brodhurst stated, that in consultation with another surgeon, he had recently seen a family, in which four members out of nine were affected with this complaint. Two had died at the ages of forty-two and eighteen, the former with softening of the brain, the latter of phthisis, and other members of the family had died of phthisis and hydrocephalus.

In the instance, however, which I have just laid before the Society, the disease had been previously unheard of in the patient's family. Six surviving brothers and sisters are healthy. One brother died at about four years of age of fever. An infant, born at eight months, survived its birth only a few days. And one brother has very lately died at the age of four months and a half, of extensive tubercular disease of the lungs, and of the bronchial and mesenteric glands. A paternal uncle is, I understand, now suffering from paralysis, and head affection.

Mr. Alfred Leggatt, 21*st of October*, 1856.

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2. *Abscess in Brain; with caries of the Temporal Bone, probably Syphilitic in origin.*

J. B., æt. 18, was admitted into the London Fever Hospital on August 9th, 1856; he gave very little account of himself, complained of being generally unwell, weak, and without appetite; his head ached, but not much; his mental state seemed below par, but exhibited no peculiarity.

In a few days his appetite returned; he was able to sit up and to walk about. No particular attention was directed to the case, until he began to complain, on the 23rd of August, of headache, referred to the forehead. From this date he lay on his back, muttering complaints of his head, his back, and his shoulder; he was quite conscious, but his countenance was particularly heavy, looking, however, as if it never had had much intelligence; he was rather deaf, and answered questions tardily. The left angle of the mouth was slightly higher than the right; the left pupil a little the larger, and there was slight left ptosis; these defects of symmetry were very slight, and had even on one occasion, during the first week after they were noticed, disappeared altogether; he could move all his limbs, and could get

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out of bed without assistance. His sensibility was extremely obtuse, and in all parts he bore severe pinching without complaint. At first, the pulse was 64-72; the tongue habitually dry; bowels somewhat confined; stools passed out of bed.

A mercurial course was given, and the nape blistered without obvious result.

The patient continued to get worse and worse during September, and at the beginning of October was unable to leave his bed; was found day after day with the same stupid, expressionless aspect, paying no attention whatever when addressed, though obeying when commands were insisted on; was never more comatose than this, and was never delirious; complained occasionally of his head, not now of his back; said he did not know where his head ached, but put his hand to his forehead; answered questions as if he only half understood them, and did not care how he answered; his eyes were always open, day and night; the right entirely, the left half open; did not wink when a hand flitted before his eyes, and scarcely when the lids were touched: both pupils were dilated, the left rather the larger; both unaffected by light. Left angle of mouth higher than the right, and tongue deviated decidedly to the right; sensibility was very obtuse, apparently equally so on the two sides; he grumbled out "Don't do that," when his leg was severely pinched, but did not withdraw the limb as if hurt. Still he had power over all his limbs, raising them all when ordered; the left hand moved somewhat more readily than the right. Urine and stool passed in bed.

On October 9th, he became rapidly more insensible and difficult to rouse, and he died on the morning of October 10th.

Post-mortem.—Surface of arachnoid very dry; convolutions exceedingly closely packed; both lateral ventricles and septum lucidum pushed strongly to the right; a little fluid in posterior corner of right lateral ventricle.

In the left optic thalamus, a tumour was found lying, and projecting to its left into the white matter of the middle and posterior lobes of the cerebrum. The brain substance around was quite natural; when the tumour was exposed, it was found to be of the size of a large orange, its outer surface being formed by a dense mem-

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brane, in which large vessels ran. The contents were felt to be fluid, and through the membrane appeared of a dark colour.

On raising the brain from the base of the skull, pretty firm adhesions were found between the lower part of the middle lobe, and the petrous part of the temporal bone; and an attempt to break down these adhesions was followed by rupture of the brain substance, and by the escape of five or six ounces of fluid pus of typical characters from the tumour in the brain. The thin layer of brain substance that intervened between this abscess and the bone, was of a deep grey colour, otherwise the brain substance was everywhere healthy. The dura mater of the base of the skull was finely injected, and was destroyed for a space of the size of a fourpenny-piece, over the semi-circular canals, at the point of adhesion; here there was a dark, soft, and carious spot of bone.

The weight of the cerebrum, after the escape of all the pus, was thirty-nine ounces and a half avoirdupois.

The rest of the brain, cerebellum, medulla oblongata, spinal cord, and the apparent origins of the cranial nerves exhibited no peculiarity whatever.

The lungs were healthy; there was no deposit in them; all the other organs of the body appeared free from disease.

Before an incision was made into the body, a scar of a bubo was observed in the left groin. On examining the prepuce, the frænum was found wanting, and a depression on the glans where it should be.

Dr. Buchanan, 21*st of October*, 1856.

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3. *Spina Bifida, treated by Puncture, producing Opisthotonos. Death from Diffuse Inflammation of the Membranes of the Cord.*

L. M., æt. 20, admitted into St. George's Hospital under the care of Mr. Tatum, on account of a tumour of the buttock.

This patient was a Welshman, and could hardly speak any English; but, as far as the account which he and his friends gave of the case could be understood, it seemed that the swelling had existed from the time of birth, and had been gradually increasing up to that period, without giving him any pain, or

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occasioning any disturbance to the functions of the spinal cord, except on two or three occasions, at distant intervals, when the tumour burst from ulceration of the skin. At these times it was said that involuntary movements of the limbs were noticed, and that the bowels acted unconsciously.

The tumour was larger than a man's head, situated at the lower part of the sacral region, and attached by a broad short pedicle, as it was supposed, to the lower part of the sacrum in the middle line. The lowest part of this pedicle was about two inches from the anus. The parts in this neighbourhood were a good deal thickened, so that the deep connection of the tumour could not be accurately made out. Its contents fluctuated very distinctly, its surface was covered by large tortuous veins, and the skin was ulcerated in one or two places from the irritation of his clothes. He seemed in good health, and suffered no inconvenience from the swelling except what was occasioned by its enormous size. This annoyance, however, was so great that he was willing to submit to any operation that would afford him a prospect of cure.

The tumour was punctured with a grooved needle, and found to contain a clear, transparent, light brown fluid, differing from the serum of the blood in containing a much less quantity of albumen.

Five days after admission a trocar was introduced at the lower part of the swelling, a little to one side of the middle line, and about half a wash-hand basinful of this fluid drawn off. This left the tumour about the size of his head.

Two days after the tapping, erysipelas appeared round the punctures. He complained of pain in the belly and in the head, and it was noticed that he kept the head drawn backwards. The pulse was rather weak; but few constitutional symptoms were noticed. Wine and diffusible stimulants were given.

Next day the urine and fæces were passed involuntarily, and the head was still further retracted. No muscles appeared then affected, except the deep muscles at the back of the neck. This retraction increased during the next three days, accompanied by pain about the lower part of the sternum, and difficulty of swallowing. The latter, however, was probably due only to the

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position of the head, which, on the third day of the attack, was noticed to be pulled back, so as almost to make a right angle with the spine. This position was not noticed to be altered in sleep. The treatment consisted in the exhibition of mercury in the form of the bichloride. The erysipelas of the skin soon subsided; but the opisthotonos continued, with rapidly increasing prostration. On the sixth day after the tapping, and fourth after the attack of erysipelas, the tumour gave way, from extension of one of the ulcerations previously noticed, and its contents were almost all discharged in the course of the day. His strength continued to fail rapidly, and he died in the evening.

On *post-mortem* examination the sac was seen to be lined by a membrane resembling mucous membrane in appearance, highly vascular and coated, in some places, with lymph. At the upper part of the neck of the sac was an aperture, apparently in the situation of the natural orifice of the sacral canal, and leading into the subarachnoidean space. The bones seemed perfectly ossified. The membranes of the cord were much thickened. Extending along the cord from its lower end to about the middle of the dorsal region, was a collection of pus, and the cord, in this situation, was softened in the parts adjacent to the purulent fluid; otherwise, it was quite healthy. None of the spinal nerves were found to communicate with the sac. There was a large quantity of cerebro-spinal fluid, which was opaque, and of a dull grey colour. The cranium was perfectly ossified, but very thin. The brain and the rest of the viscera were healthy.

Mr. T. Holmes, *2nd of December*, 1856.

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4. *Abscess of the Brain, communicating with the Temporal Bone.*

A female, æt. 33, applied to the St. Marylebone Eye and Ear Institution on the 13th of August, 1856, complaining of long standing intense pain in the left temporal region, accompanied with occasional confusion of intellect and deafness of the left ear, from which there had been of late a purulent discharge. The external passage was too painful and swollen to permit a careful examination. From the intensity of the pain, and the general symptom of cerebral confusion, although there was an entire

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absence of palsy or paralysis, there was supposed to be acute disease of the brain in the region of the temporal bone. On the fifth day from her application for treatment, she suddenly died in a convulsion. The *post-mortem* examination showed general congestion of the vessels in the left cerebrum, the middle portion of which was occupied by an abscess apparently of long standing, and containing about an ounce and a half of greenish brown coloured pus. The dura mater was firmly attached to the temporal bone; a portion of this membrane, the size of a shilling was destroyed by ulceration, and the circumference of the ulceration adhered to the petrous portion, which formed the external boundary of the abscess, the bone at this part being slightly discoloured, and perforated by several small foramina, which permitted the passage of pus into the external meatus; the lining membrane of this passage was also in a state of ulceration at its posterior and superior part. The tympanic cavity contained a purulent deposit, and its upper wall was perforated by foramina. Mr. Obrè expressed an opinion that the disease in this case originated in the brain, and not in the bone, as was generally found to be the case.

MR. HENRY OBRE, 16*th of December*, 1856.

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5. *Fibro-cellular Tumour of the Dura Mater.*

The specimen consisted of a part of the summit of the right hemisphere of the brain, and a portion of the dura mater, with the corresponding superior longitudinal sinus (Plate I. Fig. 1). Within the substance of this portion of the dura mater, was a rounded growth, of the size of a small walnut, projecting downwards, and indenting the cerebral convolutions, and also somewhat upwards and inwards so as to lessen the capacity of the longitudinal sinus, which was otherwise healthy. The texture of the growth was firm and close, having a kind of seam or cicatrix-like part in its centre, firmer than surrounding parts; the entire growth was of a reddish-brown colour. The under surface of the growth was found to be quite smooth when separated from the brain, to which it was slightly adherent, and to be covered by fine ramifying blood-vessels.

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Microscopical examination shewed the growth to consist of a large quantity of fibrous tissue (Fig. 2) in which great numbers of cell forms and blood-vessels existed. The cells (Fig. 3) were of various sizes and shapes, being chiefly large and of a round and oval form. Several of the smaller ones, being isolated, contained semi-opaque granular contents with highly refracting bodies like nucleoli; others again contained one or two large nuclei with granular contents. The larger ones which were for the most part nucleated and very well defined in outline, were collected in groups of two or three, and surrounded by concentrically laminated epithelium-like cells, forming a kind of capsule or nest. Here and there amongst these surrounding flattened cells, round and oval cells were seen, which, as it were, had escaped compression and interrupted the lamination. In many places these larger cells, or groups of cells were embedded in a number of large elongated oat- or somewhat diamond-shaped cells arranged side by side in a tesselated manner (Fig. 4). Most of the large thick-walled blood-vessels which were so numerous were surrounded by similar forms (Fig. 5). Besides the above, cells of very irregular shapes, in some cases mere plates, as it were, with nuclei attached to their walls, were here and there found.

The brain, even where indented by the growth, showed no morbid appearance. The lungs were in a state of so called red and grey hepatization, and the pleural sac on one side contained inflammatory products. The heart was very large, and its cavities dilated, with diseased aortic and mitral valves. The liver was natural; the spleen was large and firm; the kidneys were granular and unusually yellow as to their cortex. The inner half of the wall, as well as the lining surface of the uterus, was of a peculiar dark red colour as if from extravasation of blood. There was much calcareous and atheromatous deposit in the walls of the abdominal aorta.

The specimen was removed from the body of E. M. æt. 70, a woman who had had a large family and lived very poorly, being constantly exposed to damp and cold. She was admitted into St. George's Hospital suffering from increased impulse and palpitation of the heart, dyspnœa, cough, and expectoration of frothy blood-stained fluid, with physical indications of pneumonia.

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DESCRIPTION OF PLATE I.

Figures 1 to 5 illustrate Dr. Ogle's case of Fibro-cellular Tumour of the Dura Mater, p. 13.

Fig. 1. Section through the tumour and the parts connected with it, of the natural size.

Fig. 2. Fibrous tissue forming the chief constituent of the growth.

Fig. 3. Cells obtained from the growth.

Fig. 4. Large rounded cells embedded in tissue formed of diamond-shaped flattened cells.

Fig. 5. Portion of a blood-vessel from the growth, surrounded by similar large cells.

Figures 2 to 5 magnified 300 diameters.

Figures 6 to 8 illustrate the Microscopic Characters in Mr. Sibley's case of Villous Growth on the Dura Mater, p. 18.

Fig. 6. Villi from the growth.

Fig. 7. Cells from the villi.

Fig. 8. Cells chiefly from the base of the growth.

Figure 9 illustrates the Microscopic Structure of Mr. Nunn's case of Neuroma, as described by Mr. Sibley, p. 20.

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Fig 2

Fig 3

Fig 4

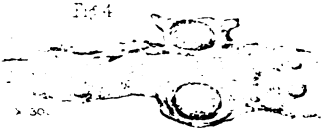

Fig 5

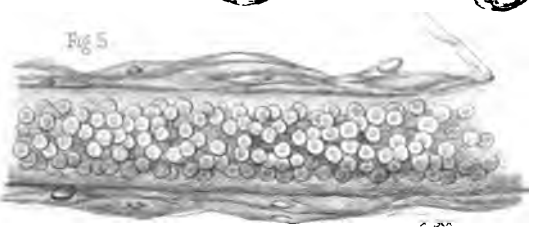

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Fig 6

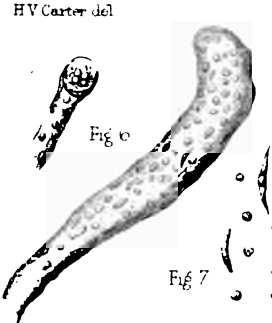
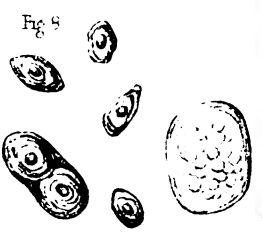


Fig 7

Fig 8



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Temporary relief only was obtained from stimulants and diuretics, and the patient sank after great suffering from extreme orthopnœa.

Remarks.—The patient had no symptoms in any way referable to the tumour, which was doubtless of very long standing, and no history was elicited showing that any brain symptoms had ever existed.

Dr. John Ogle, *16th of December*, 1856.

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6. *Softening of the Spinal Cord near its Termination.*

The specimen was removed from a male patient, æt. 34, who died in the Somerset County Asylum, under the care of Dr. Boyd, and was admitted, two years before his death, in a state of dementia. He was reported obstinate in disposition, irritable in temper, and of indolent habits; his illness was attributed to an injury to the head received some years previously. On 2nd of August, 1856, he was reported in the Hospital Journal as imbecile, conversation incoherent, ideas wandering, memory weak, and general health indifferent; pulse eighty-four; appetite good; bowels regular; his gait slow and unsteady; he complained of occasional pain in the head, and had a twitching of the muscles of the face. On the 9th he was suddenly attacked with convulsions and spasmodic twitchings of the limbs. His face had a very confused expression; but he had not lost his consciousness. He continued under treatment for occasional convulsions and twitchings of his face until the end of November, when he died.

The body was examined twenty-nine hours after death. The sac of the arachnoid contained about one ounce and a half of serum; the substance of the brain firm; cortical structure unusually dark. The right cerebral hemisphere weighed two ounces and a half more than the left. The spinal cord was softened in the lumbar region, having a soft, cream-like appearance; its arachnoid covering was natural.

Mr. H. Obre, *20th of January*, 1857.

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7. *Softening of Spinal Cord, with Purulent Deposit within the Spinal Arachnoid.*

This specimen was removed from a male patient, æt. 40, who died in the Somerset County Asylum, under Dr. Boyd's care, on the 8th of January, 1857. He had been under treatment ten months, with general paralysis combined with melancholia. In November he had an attack of convulsions, which was followed by a general loss of power and total inability to stand. His paralytic symptoms gradually got worse, and he was unable to control the sphincters, and had quite lost all power in his lower limbs some time before death. The right cerebral hemisphere weighed eighteen ounces and a half, being one ounce less than the left; the spinal cord was softened, and in parts had a soft and cream-like appearance; the arachnoid membrane was generally inflamed, and its inner surface was covered by fœtid pus.

Mr. H. Obre, *20th of January*, 1857.

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8. *Fatty Tumour from the Sacrum of a Child, connected with the Spinal Membranes.*

The tumour exhibited was removed from the back of a male child, æt. 10 months. The little patient was born, according to the statement of the mother, with an ulcer over the sacrum, but no perceptible swelling in that situation. When three weeks old he was brought to the Hospital for Sick Children; there was, at that time, an ulcer about the size of half-a-crown over the sacrum, rather to the right side of the middle line. The ulcer was seated on a slight, ill-defined swelling, and by its side was a small pendulous excrescence of fat covered with integument.

The sore gradually healed, and has remained so ever since, leaving a cicatrix to mark its situation, but the swelling underneath steadily, though slowly, increased in size, without however, being attended with any inconvenience to the child, whose general health remained excellent till the beginning of January in the present year. The swelling at this time enlarged rapidly, and the child began to suffer from frequent twitchings or convulsive movements, affecting the right leg only, to such an extent as to make the parents anxious to have something done.

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On the 3rd of February, it was determined to operate. At this time the swelling was about the size of a small orange, but broad and not clearly defined at its base. It was soft and doughy, feeling like fat; not tender to the touch, and situated over the sacrum, a little to the right of the median line. The pendulous excrescence had now attained the size of a large pea.

After cutting through a mass of fat which was not circumscribed nor contained in any distinct capsule, the glistening surface of a membrane surrounding a distinct fatty mass, constituting a separate tumour, was exposed. On proceeding to remove this, it was found to be adherent to the parts beneath, requiring careful dissection, as it protruded through an aperture large enough to admit the end of the finger, in the posterior wall of the sacral canal. Rising up to the level of this opening was a soft mass connected with the interior of the canal, formed by the membranes enveloping the spinal cord, and exhibiting a distinct pulsatory movement synchronous with the respiration. The tumour was adherent to these membranes, from which it was dissected off, without any opening having been made in them.

The child did well after the operation. The convulsive movements of the lower extremity ceased, and the little patient was taken home at the end of a fortnight, the wound being in process of healing.

The fatty mass exhibited before the Society measured about one inch and a half across, by one inch in depth. It was composed of a fine fat, somewhat lobular, with a thin, but distinct capsule, except at its base where it had been adherent to the membranes.

Remarks.—One or two points of interest appear to me to be presented by this case.

In the first place, with respect to the infrequency of fatty tumours in very early life. In a remarkable case exhibited before this Society, at the beginning of the present session, by Mr. Pollock, in which the fatty tumour commenced at the age of eighteen months, the author remarked that he had not been able to meet with any account of such a tumour at so early an age. In the present case it was probably congenital.

Secondly, the tumour is remarkable as respects its situation in

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the interior of the spinal canal, and the co-existence of a deficiency of the laminæ allowing the tumour to make its way externally.

In a case reported in the Transactions of this Society for 1851-2, by Mr. Obrè, an accumulation of fat was found after death in the upper part of the spinal canal of a child, three years old, who had suffered from partial paralysis of the right arm and leg. Here, however, the bony walls were entire, and of course, the exact nature of the affection could not have been suspected during life.

Lastly, the movements of the cerebro-spinal fluid in the spine, synchronous with the respiration, and which were in this case plainly visible, were interesting, as, though minutely described by Magendie, as well as by Cruveilhier and others, their existence is not perhaps universally known, and have possibly not been actually demonstrated in the human subject where no spina bifida existed.* Mr. Athol Johnson, 17*th of February*, 1857.

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9. *Villous Growth on the Dura Mater.*

This specimen was removed from the head of a woman, æt. 56, who died in the Middlesex Hospital in November, 1856, under the care of Mr. Shaw. The patient had laboured under symptoms of uterine cancer for two years before her death, and with these she sank, without having manifested any symptoms of disease within the skull.

The tumour was about the size of a nut, and was growing from the dura mater close to the falx near the vertex. The growth was of a reddish-grey colour, and to the naked eye was evidently composed of a large number of villi or papillæ, mostly arranged parallel to one another, and growing from the surface of the membrane. Some of these villi were as much as a quarter of an inch in length. The dura mater near the growth was ossified, spicula of bone shooting into the membrane for some little distance around. The other membranes of the brain were free from disease; the Pacchionian bodies were not extremely large or numerous. The convolutions of the brain opposite the little tumours were smaller, forming a depression

* The specimen described at p. 28, forms the sequel to this case.

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corresponding to it; on section, the brain substance was found unaltered in colour and consistence.

The only other disease, which was found in the body, was that of the uterus. This organ was enlarged to about the size at the fourth month of pregnancy, the cavity being distended by a mass of soft encephaloid disease. The major portion of this was white and semi-transparent, other portions being opaque, like thick cream. A large patch, of irregular form, near the middle of the tumour, presented the yellow colour and general characters of what is usually termed the phymatoid degeneration of cancer. The walls of the uterus and the cervix were free from disease. Neither the lumbar nor any other lymphatic glands were enlarged or cancerous.

The microscopical examination of the tumour proved its structure to be essentially similar to that of villous disease in other parts of the body, as, for instance, in the bladder.* There were, however, one or two points of distinction. In the first place, in the growth on the dura mater, the villi were larger, and somewhat straighter than those in the bladder. In the present instance, also, the villi exhibited less tendency to branch and shoot out in all directions (Plate I. Fig. 6).

In addition to the ordinary spherical and fusiform cells which are found in similar growths (Fig. 7), there were numerous "brood cells" and "epidermic globes" (Fig. 8), very similar to those which are found so abundantly in cases of epithelial cancer. These cells were seen in nearly all parts of the growth, but they existed in greatest abundance near its base.

The epidermic globes were extremely numerous, and had the appearance of a number of flat scales, packed and flattened out on the inside of a larger, or parent cell. Other bodies were seen, composed of a large number of young cells nearly spherical in form, packed closely together, and surrounded either by a parent cell, or, in many instances, by several laminæ, similar to the simple epidermic globes.

Mr. Sibley, *17th of February*, 1857.

* "Path. Soc. Trans." vol. vii. p. 214.

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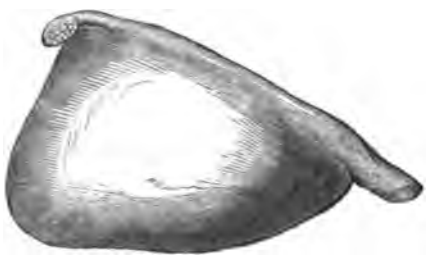
10. *Two specimens of Neuroma.*

The first of these specimens was excised by Mr. Nunn from the arm of a young lady æt. 20. The tumour was situated just above the bend of the elbow and involved the musculo spiral nerve. It had been growing for twelve months, and was painless, except when struck; but its situation exposing it to frequent injury, the tumour had become the source of great inconvenience.

After removal, the growth was about the size of a large walnut, its form being somewhat ovoid. It was plump, soft, and elastic, and was surrounded by a thick fibrous envelope, continuous with the sheath of the nerve (Fig 1). The examination of the tumours

Fig. 1.



Represents the tumour of the natural size.

was made by Mr. Nunn and Mr. Sibley. The nerve itself appeared to pass through the upper border of the mass. A slight amount of dissection was sufficient, however, to remove the fibrous cyst from the neuroma and the nerve. A few small vessels passed from the capsule into the surface of the tumour. The cyst being removed, the neuroma itself presented a peculiar delicate reddish-yellow tint; the surface was smooth, moist, glistening, and semi-transparent. On cutting into the tissue of the tumour, it was soft and œdematous, serum escaping abundantly from the cut surface.

At this stage of the dissection it would be seen that the neuroma involved only a small portion of the nerve-fibres; more

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than three-fourths of the whole bulk of the nerve passing on unaffected, and even uncompressed by the tumour. The remaining portion of the nerve-fibres were seen to be involved in the growth; several bundles of fibres passing into the tumour, and others from it joining the efferent nerve. One or two small bundles of nerve-fibre could be seen to run in the semi-transparent tissue of the growth, and having passed round the convex border, to rejoin the nerve. The tumour was then hardened in spirit, in order to trace more completely the course of the nerve. A considerable number of nerve-fibres were traced, entering the tumour at different points; whilst, in the same manner, others found their exit from the growth, and rejoined the nerve. Some small nerves were followed, for a considerable distance, into the substance of the growth, their nervous structure being proved by microscopical examination (Fig. 2). The only fibres

Fig. 2.

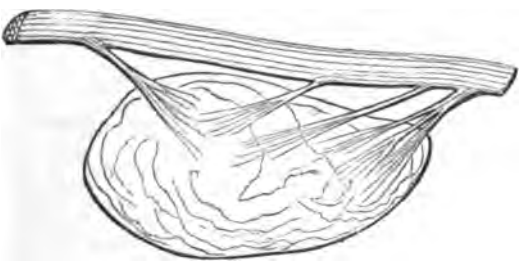

Diagram to shew the arrangement of the nerve-fibres in the tumour.

that were traced to pass completely through the tumour and again join the nerve, were those that were seen before it was hardened in spirit. In one or two instances, on tracing a minute nerve into the tumour, its microscopical structure appeared to become degenerated or transformed into simple connective tissue. This might assist in explaining the somewhat singular fact, that a larger quantity of nerve-fibres entered than escaped from the tumour.

The microscopical examination of the tumour, when in the recent state, proved it to be composed chiefly of a connective tissue similar to that of a fœtus. It was formed of fibres (Plate I. Fig. 9) interlacing and running in all directions. Each fibre

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was made up of a bundle of delicate waved fibrils. Small oval and a few oat-shaped nuclei were observed scattered in all directions among the fibres. Acetic acid made evident the presence of a small number of elastic fibres.

In addition to the connective tissue, a large number of vessels were observed forming a close capillary net-work throughout the tumour. The capillaries themselves were of rather large diameter. The walls of the minute vessels were thin and delicate; oval nuclei were very numerous on their surfaces.

The second specimen was removed from the neck of a woman æt. about 40, by Mr. Barber, Surgeon to the Stamford Infirmary. It had been growing for several years, and had given rise to the most intense pain and exquisite tenderness which could not be relieved by any local applications. The tumour was excised by Mr. Barber and was found to involve the fifth and sixth cervical nerves at their exit from the intervertebral foramina. The wound, after the operation, healed up without trouble, and the patient made an excellent recovery, considerable loss of power in the arm, of course, resulting.

When recently removed, the tumour weighed two drachms and a half, and measured one inch and three-quarters in length. The form was ovoid, the proximal end being larger than the distal. Two nerves (the fifth and sixth cervical) entered the proximal side of the tumour; but they united, so that only one came from the apex of the tumour. It was enveloped in a fibrous capsule, which, as in the first specimen, was derived from the sheath of the nerves. So, also, as in the former case, only a portion of the nerve-fibres were involved in the new growth, the major portion passing on unaffected by the tumour. A large bundle of nerve-fibres within the capsule was flattened out into a sort of membranous expansion, apparently from the presence of the growth. On making a section of the tumour, the central portion was found to be softened and broken down.

The tumour was examined microscopically after it had been preserved for some time in spirit, and its structure, as far as could be made out, was very similar to that of the first specimen.

The contrast in the symptoms produced by the growth in these two cases is very remarkable. In the first case the tumour had

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grown altogether without pain, and only gave rise to inconvenience when it was subjected to violence. In the second instance it produced most intense pain and cutaneous sensibility.

Mr. SIBLEY, *17th of February*, 1857.

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11. *Spina Bifida, with Hydrocephalus. Serous Canal through the whole length of Spinal Cord.*

The subject of this case, a little boy, æt. 15 months, had died in consequence of the spontaneous rupture of a large sacral spina bifida. Mr. Hutchinson had seen him about a fortnight prior to death, in consultation with Mr. Marsh, of St. John's Street, who had attended the case from the time of birth, and to whom he was indebted for permission to bring the specimen before the Society. At the time of birth the tumour, which covered the lower sacral region, did not bulge much, but not long afterwards it began to fill, and the infant's head also enlarged. In spite of these affections, however, the child grew, and appeared of average intelligence. His lower extremities were wasted and the feet drawn upwards (talipes calcaneus). On several occasions the question as to propriety of puncturing the tumour with a fine trocar was entertained, but always decided in the negative, on account of the existing cranial disease. The head went on increasing until it became fully twice the natural size. Two weeks prior to death the spina bifida was as large as a fœtal head, and the skin over it stretched, and very thin. A few days later it gave way and collapsed. The fluid drained away by a mere pin-hole opening, and no suppuration occurred. The drain, however, was more than the infant's strength could bear, and it sank from exhaustion. Some diminution in the size of the head had been noticed during the last few days of life. At the autopsy the lateral ventricles of the brain were found distended by more than a pint of clear serum, the septum being wholly destroyed. The ventricle of the medulla oblongata was also distended, and passing down from its lower extremity was a canal about as large as a crow-quill, which ran the whole length of the spinal medulla in its centre, and terminated in a large bag of arachnoid membrane, which hung in the cyst of the spina bifida. This sac,

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which would have held a pigeon's egg, had no communication with the larger cyst, and evidently consisted of the terminal prolongation of the ventricular lining membrane. The spina bifida itself presented nothing unusual. The laminæ of the sacrum were wholly wanting, and several nerves of some size were attached to the walls of the cyst. Excepting one or two flakes of lymph, there were no evidences of inflammation. Mr. Hutchinson remarked upon the interest which attached to the canal which passed the whole length of the cord connecting the cerebral ventricles with a serous sac at the cauda equina. It was no doubt a relic of fœtal structure, and an evidence of the tendency to effusion into the cerebral and spinal cavities having existed during intra-uterine life. He was not aware of the existence of any similar specimen.

Mr. HUTCHINSON, *3rd of March*, 1857.

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12. *The Spinal Cord after Death from Strychnia.*

In March, 1831, a man, æt. 46, was treated, under Dr. Booth's care, in the Birmingham General Hospital, for hemiplegia of the left half of his body. Strychnia was administered, commencing with half a grain twice a day, which dose, during five days, produced no sensible effects. On the tenth day the dose was increased to a grain, and soon after the specific effects of the drug were shown. On the fourteenth day the remedy seemed to be losing its power, and an addition to the dose was accordingly ordered. On the morning of the sixteenth day, he took, for the first time, a dose containing a grain and a half. (It must be remembered that the strychnia then in use was a simple salt, and not nearly so potent as that now supplied). Soon after taking this large dose, however, unmistakeable symptoms of poisoning were manifested. The man seemed greatly excited, and his countenance and gestures manifested an unusual eagerness and solicitude. In about three hours stupor came on, with loss of speech, and this was followed by severe tetanic spasms. His pulse was irregular and fluttering, the breathing short and laborious, the pupils dilated and insensible to light. After about twenty minutes, the violence of the convulsions abated,

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and he seemed better; but subsequently a relapse took place, the body was now rigidly and permanently bent backwards, the pulse became imperceptible, cold sweats covered the surface, and in a paroxysm of suffocating dyspnœa, death took place. He expired two hours and three quarters after having taken the poisonous dose.

At the autopsy, seven hours after death, the whole muscular system was found in a state of spastic rigidity. A considerable quantity of blood flowed on division of the scalp, and the vessels of the dura mater were found turgid with dark blood. In the right corpus striatum was a large old apoplectic clot, dark-coloured and grumous, around which the brain substance was softened. The lateral ventricles contained about one ounce and a half of yellow serum. The other parts of the brain were healthy. The investing membranes of the spine were highly congested, the pia mater, especially, being of a florid redness. Between the pia mater and arachnoid were a series of ecchymoses, four of which were of larger size than the rest. These were situate opposite to the last dorsal and first lumbar vertebræ, that near the last being a coagulum of considerable size. The cord itself appeared healthy. The thorax and abdomen were not examined, owing to the interference of the friends.

The specimen shown to the Society consisted of the spinal cord. Although kept in spirit for more than twenty years, the extravasated patches of blood were still clearly seen.

Mr. Hutchinson for Mr. Hartin, *3rd of March*, 1857.

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13. *Malignant Tumours of the Brain, after removal of an Encephaloid Breast.*

I am indebted to Mr. Solly for permission to exhibit these specimens. They had been removed from the brain of a female, æt. 48, who, about two years previously, had suffered from encephaloid disease of the breast. This breast was removed, and the patient went on well till last November, when she began to complain of very severe and incessant pain in the head, and always referred to the vertex. This was the only symptom till some little time before her death, when motion began to be impaired

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in the left side, and she had occasional convulsive attacks. After death only the head was examined; embedded in the left hemisphere was a tumour about the size of a marble, resting upon the corpus callosum, and projecting somewhat into the longitudinal fissure. A smaller one, about the size of a bean, was found on the outer side of the right corpus striatum. The tissue of of these tumours was firmer than that of the brain tissue, in which they might be felt as comparatively hard nodules—their section was of a yellow colour, and yielded a copious creamy juice: the cerebral substance in their immediate neighbourhood was much softened; and its red colour shewed its increased vascularity. A microscopical examination shewed nuclei, round and oval, varying in size from $\frac{1}{1250}$th to $\frac{1}{625}$th of an inch in diameter, with, or without a nucleolus. Some few of them were clear, or only very minutely granular: but the greater number were filled with dark oily matter. Besides these, were cells, generally of very large size, containing a number of nuclei; the largest had a diameter of $\frac{1}{330}$th of an inch, whilst the smallest were only $\frac{1}{1000}$th of an inch: the larger ones, however, predominated, and generally contained three or four large nuclei ($\frac{1}{830}$th of an inch in diameter), each nuclei having a nucleus, large and distinct, and varying from the $\frac{1}{2500}$th to the $\frac{1}{1250}$th of an inch in diameter.

In the growing part of the tumours, *i.e.*, at their circumference, the cells were most abundant: and it seems that in them granular matter is afterwards collected, and that they eventually burst and discharge their nuclei and granular matter.

Mr. Sydney Jones, *17th of March*, 1857.

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14. *Extensive Osseous Deposit in the Dura Mater.*

The specimen was removed from the body of a single woman, æt. 48, who died in the Middlesex Hospital, of cancer of the liver. As far as can be ascertained she never exhibited any symptoms referable to disease within the cranium.

The deposit (Fig. 3.) consisted of flattened plates of bone on the inner surface of the dura mater, of very irregular shape, and varying in size from minute granules, to a piece which measured two inches and eight lines in length, by two inches and a half in

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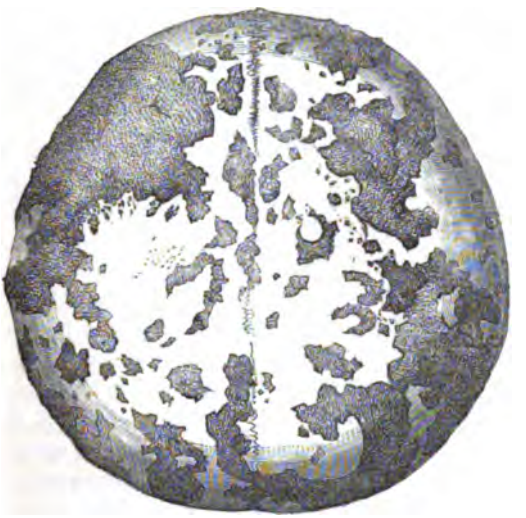
breadth, and was nearly a quarter of an inch thick in some places; their outer surface was smooth and flat; on the inner side they were mostly uneven and nodulated.

Fig. 3.



Represents the dura mater, with the numerous patches of bone deposit covering its surface.

The deposit occupied nearly the whole of the upper portion of the dura mater, and the extent of it is seen in the accompanying drawing, taken from the preparation after it was dried, in which the bony parts are shaded: there was none in the falx, except along its attached margin, or in the sensorium, or in the dura mater lining the base of the skull. The brain appeared healthy, with the exception of a preternatural congestion of the vessels of the pia mater.

Examined microscopically, the deposit presented the character of true bone, having Haversian canals, lacunæ and canaliculi.

Mr. W. H. Flower, *7th of April*, 1857.

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15. *Fatty Tumour connected with the interior of the Spinal Canal of the Sacrum.*

This specimen afforded a sequel to the case brought before the Pathological Society on the 17th of February of the present year* being taken from the same patient. Mr. Athol Johnson, at that time, showed a fatty tumour which he had removed from the region of the sacrum, and which he stated passed deeply into the sacral canal, and was adherent to the membranes of the cord from which it was dissected. The child recovered from the operation, and was taken home, the wound having healed, and the symptoms of nervous irritation disappeared. The little patient continued well for six weeks, and was even able to stand, and was beginning to walk a little, when it was attacked with acute peritonitis, affecting principally the region of the liver, and died in a couple of days. Mr. Johnson having been informed of the death, had an opportunity of examining the body, and removed the whole of the sacrum which he exhibited to the Society.

The cicatrix was adherent to the membranes of the spinal cord, which were somewhat protruded through an opening in the back part of the sacral canal, extending downwards from the level of the inferior margin of the sacro iliac synchondrosis, below which point the laminæ were almost entirely deficient. On opening the membranes, the protrusion was found to be caused by a large fatty mass adherent to these membranes below, but free above, where it formed, inside the theca, a smooth conical circumscribed tumour, resembling the end of a finger, situated behind and pressing upon, the spinal cord, and separating it, as it were, from the back part of the theca, so as to leave a considerable space above it occupied by the cerebro spinal fluid. There was no inflammation whatever about the cord or its membranes throughout their whole extent.

Dr. Vandyke Carter, who was kind enough to examine the specimen, gives the following more minute description of it:—

"I find the greater part of the fatty mass placed within the dura mater, which is stretched over it, and has become much thinned. The tumour has pressed upon the spinal cord (found in

* *Vide* p. 16 of this volume.

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this part of the vertebral canal at this early age), and has involved the roots of origin of the lowest spinal nerves so completely that they seem to be embedded in its substance. The direction of pressure, as well as of growth, seems to have been from below upwards, and from behind forwards. It may be conjectured that the tumour commenced quite at the extremity of the vertebral canal; it may be, being connected with the bodies of the lowest sacral or coccygeal vertebræ, and that it found an easy entrance into the canal through its here unclosed termination. Growth probably took place outwards, at the same time, forming the external tumour, and a distinct lobule may be seen placed between the dura mater and the periosteum of the sacral canal." This extends up the canal for about an inch, making its way to the right side, and rather in front of the sheath, its base being attached to the main tumour and to the membranes, the apex being free and rounded.

"The situation of the main part of the tumour easily accounts for the phenomena observed during the preceding operation. Connected no doubt with the presence of this tumour may be seen a malformation of the lower sacral vertebræ. From the body of the third downwards they are displaced to the left side, and small in size; the deficient space being filled up with strong fibrous tissue. This deficiency corresponds with the front part of the arch of these vertebræ. The whole deformity may be considered as the result of pressure and consequent non-development of certain parts. The coccyx resumes its normal position."

Mr. Athol Johnson, *5th of May*, 1857.

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16. *Disease of the Bones of the Head, consequent on a Blow. Tumour of the Brain. Epilepsy.*

The specimens had been removed from the body of a boy, æt. 13, who, four years before his death, had been struck on the left side of the head by a schoolmaster. He complained from this time forward, more or less, constantly of pain in the side of his head. He became, within a few months, subject to epileptic seizures, more or less severe, which returned at tolerably regular intervals of three or four weeks. He also

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became the subject of disease of the hip-joint. There was said to be no paralysis. A variety of treatment was used without success, and he finally sank exhausted.

A portion of the parietal bone showed a thickening to nearly three times its natural depth. The corresponding surface of the bone internally, to the size of a florin, was rough and irregular. The dura mater, which was of a dark colour, was partially destroyed where it had been attached to the bones. This disease corresponded to a tumour the size of a small orange, situated in the substance of the left hemisphere of the brain just over the fissure of Sylvius. The outer portion of this tumour consisted of a reddish layer, feeling firm but easily broken down. The microscope showed it to be composed of brain-tissue, and exudation elements. Within this layer was a calcified mass, the size of a walnut. It closely approached the surface of the brain, and may have been connected with the dura mater before the skull cap had been removed. The microscope showed this mass (in sections made by Dr. Stone) to contain imperfect cancelli and to be imperfect bone.

Dr. QUAIN *for* Dr. WRAY, 19*th of May*, 1857.

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17. *Spina Bifida.*

A. S., æt. 9 weeks. The tumour was situated at the lower part of the spinal column. No spines felt below the tumour. The anus seemed to be at least half an inch higher than natural, being also more than one inch from commencement of the scrotum. Between the anus and the tumour was a blind pin-hole foramen.

The integument of the tumour during life was transparent, the surface irregular, being prominent at different points, as if the tumour was divided by septa. After death the integument had lost its transparency, and on section, the insertion of the spinal nerves into the posterior of the sac along the middle line was seen.

The frontal suture of the child was open, measuring half an inch at the nose, and fully two inches at the widest part. This seemed to be from deficiency of ossification, and not from disten-

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tion, though there was fluid within the cranium. The other sutures were normal. The general contour of the head natural, except only the flattening of the forehead where the bone was wanting.

Two inches of ileum, the cæcum, and two inches and a half of colon were herniated through an opening, which would admit the middle finger, into the scrotum.

The general nourishment of the child was good, except that the right lower extremity was atrophied, and the foot incurved, a condition noticed at birth; the left foot also was slightly incurved.

When the child was one week old, the tumour was punctured. I saw the child, with Mr. Price, three weeks before death; it seemed to suffer no inconvenience, unless pressure was made on the tumour, and then it cried, but did not become drowsy. A fortnight before death it was convulsed; the fontanelle was much distended; temporary relief was afforded by puncturing the tumour. The child sank exhausted.

Five days after death, with the assistance of Dr. John Ogle, I made a *post-mortem* examination. The specimen was afterwards dissected by the same gentleman, and may be seen in the museum of St. George's Hospital.

Dr. W. Ogle, *19th of May*, 1857.

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18. *Traumatic Inflammatory softening of the Spinal Cord, producing Paraplegia.*

R. P., æt. 8, was admitted into the London Hospital, on Saturday, 6th of December, 1856, under the care of Mr. Curling, on account of partial paraplegia, the result of an accident. There was some difficulty in obtaining a satisfactory history of the case; but it appeared that, on the previous Monday, while sliding in a gutter, the boy had fallen down on his nates, with his legs wide apart. He managed afterwards to crawl home, where he remained until the day of his admission, nothing having been done for his relief. He had entirely lost the use of his lower extremities, and sensation was also impaired. No injury to the spine could be detected. The case was viewed

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as one of concussion of the spinal cord. The loss of sensation increased, and, in a few days, paraplegia became complete. The boy was unable to empty his bladder, and the urine, which was healthy on his admission, shortly became turbid and ammoniacal. For about a week after his admission reflex action was readily manifested on touching the lower extremities; but this also disappeared entirely in about a fortnight. The boy's health then began to give way. Sores formed on the nates and over the trochanters, and, ultimately, over the external malleoli. The sore over the sacrum extended until it became of large size, and exposed the bone. A large abscess formed in the thigh. Diarrhœa ensued, and the boy, after manifesting a remarkable tenacity of life, died on the 27th of March. The body was examined by the house surgeon. There was no injury to the spinal column. Serous effusion was found within the theca of the spinal cord. The lower part of the cord, when incised, was found softened, and at one spot there was an appearance of pus. This part was submitted to Dr. Andrew Clarke, for more minute examination.

Examination by Dr. Andrew Clarke.—The lower part of the cord alone was submitted to me for examination. It had been laid open by an incision through its whole substance from above downwards.

The arachnoid was slightly thickened and opaque: the thickening and opacity appeared to be exclusively due to a deposition of solid albumen in a molecular form.

The pia mater was closely adherent to the cord, but otherwise free from change, except that nucleated cells were scattered over its inner surface.

The substance of the cord was diminished in density. Immediately below the cervical and above the lumbar enlargements it was softened, of an opaque white colour and opalescent. The softening in these parts was greatest on the surface, least towards the centre. The columns of the cord generally were indistinct. The grey colour of the central parts of the cord was lost; in the softened portions it exhibited a yellow hue; in no part was the normal distinction of colour preserved. Just above the lumbar

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swelling there was a small gap on the surface of the cord, which was said to have been occupied by pus. The roots of the nerves issuing from the cord and the leash of nerves in which it terminated were obviously softened.

Microscopic examination showed that the softened portions of cord consisted of the disintegrated structural elements of the cord variously changed by the new conditions under which they were placed, of numerous highly refractive granules, and compound granule cells floating in a fluid. Some of the refractive granules disappeared under the prolonged action of heated æther; those which did not disappear under the influence of this reagent were dissolved with effervescence by acetic acid. The same observation applies to some of the granule cells, though before the application of these reagents there was no apparent distinction between them.

Every other part of the cord, whether softened or not, exhibited the presence of the same new elements. In every part also where they could be examined, the smaller arteries were studded with highly refractive granules, and coated with granule cells. Mr. T. B. Curling, 19*th of May*, 1857.

19.—*Hæmorrhage into the Pons Varolii. Symptoms not unlike some of those produced in poisoning by Opium.*

H. C., æt. apparently about 60, was brought to University College Hospital, about five o'clock on Monday, 4th of May, by two women, who stated that the patient was almost a stranger to them, though she lived in the adjoining room; that an hour before her admission she knocked at their door, told them she was dying, and immediately fell senseless on the floor, and that she had since continued in the same senseless condition. The patient had mixed very little with her neighbours; but the women who brought her to the Hospital had observed her to be a steady, hard working woman, of very temperate habits.

When seen by Dr. Hare she was lying on a couch, and was perfectly comatose; pinching the arms and legs seemed to produce no effect on her. There were convulsive twitchings of the muscles of the trunk and limbs on both sides, but especially

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of the pectoral muscles, so that there was an almost constant jerking of the arms, which was nearly equal on the two sides; no tonic rigidity of any of the limbs. The face was not drawn to either side, nor the features distorted in any way. The breathing laborious, but not stertorious. Pupils intensely contracted and equally so. Pulse rather frequent, but full and strong. Believing the case to be one of apoplexy, Dr. Hare ordered the patient to be taken into one of the wards, and after seeing some other patients again visited her. In the mean time she had been seen by some of the resident medical officers, who perceived a strong odour of the breath, and two of them, together with a physician who happened to be there, though not of the Hospital staff, and all very intelligent men, concurred in thinking the odour to be narcotic in character. The stomach pump was therefore being applied when he revisited the patient, but no indication of opium was found on testing the contents of the stomach. Ice was then applied to the head and mustard to the legs; a turpentine enema was exhibited and other remedies employed, but the coma and other symptoms continued unabated up to 8 P.M., when she died. On closer examination during the evening it was found that the muscular twitchings were more marked on the right than the left side.

The *post-mortem* examination took place sixty-eight hours after death. The skull was remarkably thick, and presented scarcely any diploe. The brain appeared small, the convolutions on the anterior and upper part of the right hemisphere were distinctly flattened, and this part corresponded to a portion of the skull more particularly thickened. Section was natural except that consistence was somewhat greater than is usual; on cutting down to the level of the lateral ventricles, their surface was found to be more prominent than natural, due to their being distended with about two ounces of turbid serosity. On now further slicing the right hemisphere from before backwards, at about the middle of the thalamus, some dark coloured blood was seen to ooze from a small opening; and on further dissection the blood was found to occupy nearly the whole of the right crus cerebri, part of the left crus, and the whole substance of the pons Varolii, which was so hollowed out by it as to present little more than a kind of shell of cerebral substance

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filled with a large mass of black coagulum; the blood also extended somewhat into both hemispheres of the cerebellum, but rather more into the left than right one. The brain substance was softened around the clot. No degeneration of the vessels could be discovered. No effusion of any kind existed at the base of the brain.

The other organs of the body were healthy.

Apoplexy of the pons Varolii is so rare as to render this example of considerable interest, especially in connection with the symptoms during life. The frequent twitchings of the muscles, almost equal in amount on the two sides, the extreme contraction of the pupils, the absence of distortion of the face, the character of the breathing, &c., together with the supposed odour of the breath, were such as to make three intelligent medical men very strongly suspect that the case was one of poisoning by opium. But it may be remarked that the coma was more profound than that usually caused by this poison, and that the character of the pulse did not correspond with that produced by opium. Dr. Hare was told by his friend and colleague, Dr. Parkes, that he once met with a case of hæmorrhage into a similar part of the brain, and in that instance the symptoms which occurred were so similar to those in the case under consideration, that on hearing the symptoms detailed, and before he knew the result of the autopsy, he suggested whether there might not be effusion of blood into the pons Varolii. Mr. Hainworth, of Camden Town, has also met with one case of apoplexy of the same part of the brain, and he assured Dr. Hare the symptoms were "very similar indeed" to those above detailed.

The patient probably left her own room, and reached her neighbour's door after the attack came on; she was certainly able to knock at the adjoining door to her own, and to exclaim that she was dying—and these points are not without their interest in a medico-legal, as well as in a simply pathological point of view.

Dr. Hare, 19*th of May*, 1857.

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II.—DISEASES, ETC., OF THE ORGANS OF RESPIRATION.

1. *Encephaloid Tumour at the Root of the Left Lung.—Disease of the Substance of the same Lung.*

A. K., æt. 34, a single woman, a native of Dumfries, but latterly resident in London, was admitted on the 6th of March, 1856, under Dr. Quain's care, into the Brompton Hospital (Dr. John Sibbald being clinical assistant).

The patient was of sallow complexion, but her cheeks were generally flushed; her hair and eyes were dark. She had been employed as cook in a gentleman's family for the last sixteen years, and, consequently, was exposed to sudden changes in temperature. A brother had died of phthisis. She stated that she had enjoyed excellent health till ten years ago, when, in lifting a heavy weight, she was seized with hæmoptysis, and expectorated about a pint of blood. For six years after this she was subject to frequent attacks of a less severe character, and was much weakened by them.

About fifteen months before admission to the Hospital, she caught cold, and since then has had a cough. Within the last six months she has been subject to attacks of aphonia, lasting several weeks at a time; in the intervals she does not thoroughly regain her voice. She had night sweats at the first part of her illness, and was subject to occasional attacks of diarrhœa. The catamenia have been, and are, regular.

General symptoms.—On admission she complained of pain in the left infraclavicular region, extending back to the spine; of troublesome cough; and she had a thin frothy expectoration. She had loss of voice, difficulty of breathing, and much wheezing. The bowels were regular, the tongue furred, the skin cool, the pulse one hundred and eighteen, and the respirations forty per minute. She had little appetite.

Physical signs.—The respiration on the right side was loud and blowing, with some sonorous rhonchus; there was no dulness. At the left side, towards the apex, there existed dulness on percussion, over the space of two or three inches; the respiratory

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murmur was feeble, and here also existed some sibilant and sonorous rhonchus. There was no tenderness on pressure over the larynx.

She was treated by means of occasional counter-irritation over the upper part of the chest, salines, and subsequently tonics. On the 31st of March she was put on small doses of cod liver oil; until the middle of May she seemed to improve in general health, increasing slightly in weight, but without much remission of the local symptoms. In the commencement of June she became worse, and on the 5th, the following report was taken:—"There is diminished mobility of all the left side of the chest, with feeble respiratory murmur in the corresponding situation. There is no very marked dulness except over the upper bone of the sternum, and on each side of it. In this situation, too, there is some fulness. A loud murmur accompanies the first sound of the heart at the base,—beneath the clavicles and between the shoulders. There is no impulse as from an aneurism." She complained of pain in the left shoulder running down the left arm, and had slight difficulty in swallowing. After this time she gradually got weaker, and the difficulty of swallowing increased. The treatment consisted of attention to her diet, tonics, and purgatives when necessary; the pain was considerably relieved by the application of belladonna plasters.

On the 13th of July she complained of not being able to swallow anything at dinner; everything which did pass the fauces, except liquids, immediately returned. The physical signs continued much the same as before, the cardiac murmur being heard as loud behind as in front. There was some coarse crepitation at the base of the left lung. She was ordered strong beef tea and nourishing drinks. On the afternoon of the 15th, *i.e.* two days after, while retching after attempting to drink, she brought up a bolus of undigested beef, about the size of a chestnut, but longer, and immediately experienced very considerable relief to the dysphagia. After this time she was alternately better and worse till the beginning of October, when she complained of an increase in the severity of all her symptoms. At first she was unable to swallow solids, but soon even liquids would not pass. Being now unable to receive food by the mouth,

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she was fed by beef tea and other nutritious enemata containing also quinine.

She lingered on for about a fortnight in this condition, not suffering much actual pain, but wasting from want of sustenance, and she died exhausted on the 19th of October.

Post-mortem examination.—Thorax.—The lungs and heart were removed *en masse* along with the great vessels and trachea.

A lobulated tumour about the size of a duck's egg, was found projecting between the apex of the left lung, and the anterior portion of the arch of the aorta, displacing these parts slightly to each side. On examining the parts on their posterior aspect, the tumour was found to be somewhat prolonged into the posterior mediastinum. This pressed upon the œsophagus and against the concave portion of the arch of the aorta. The œsophagus on being partially slit up was found to be much constricted and ulcerated, at a point about opposite the third dorsal vertebra, and to be firmly adherent at this point to the tumour. On making a further examination and cutting into the tumour, the left bronchus was found embedded in its inferior portion. The bronchial glands were to some extent involved and enlarged. One chestnut-sized mass was situated between the trachea and œsophagus, a little below the level of the thyroid gland, and by its position necessarily pressed on the right recurrent nerve which was found beneath it. There were some transverse folds in the lining membrane of the lower portion of the arch of the aorta, caused evidently by the pressure of the tumour. The aortic valves were only two; one of these two being clearly formed by the breaking down of the septum between two valves which were originally separate.

The left lung at its base was infiltrated with a soft yellowish matter, less solid and resisting than tuberculous matter, resembling, in its microscopic characters, the elements of the tumour above described, and occupying the air vesicles and the intervesicular passages. In some portions the deposit had broken down, and small cavities had been formed. The elements of the tumour were seen to consist of cells well formed, small, varying in shape, containing from one to three nuclei and some nucleoli, much fatty matter, an exceedingly delicate stroma and blood-vessels. There were but few compound granular cells. The

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disease infiltrating the lung presented like microscopic characters. The pulmonary vesicles were distinctly traced filled by the deposit.

Remarks.—The interest of the case depended on the obscurity of the diagnosis in its earlier stages. Cough, loss of flesh, hæmoptysis, breathlessness, &c., were evidence of the probable presence of tubercles, an idea which was supported by the physical signs. Then came the difficulty of swallowing, and the more circumscribed character of the physical signs, which, whilst they by degrees removed all idea of tubercles only, established the existence of a tumour producing pressure. The murmur heard over the recognised seat of the tumour, and in a very suspicious situation, suggested the idea of an aneurism of the aortic arch; other signs however of this lesion were absent. Finally, as the symptom of pressure increased, without any relation to those connected with the vascular system, the idea of an aneurism was entirely given up. The symptom of the disease became so characteristic before death, that very little doubt of its real nature was entertained. Dr. QUAIN, *4th of November*, 1856.

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2. *Cirrhosis of the Lung.*

J. B., æt. 24, died in Guy's Hospital, under Dr. Hughes' care, in October, 1856. He was a single man of dissolute habits, and had drunk very freely of spirits, especially gin; four years before he was in St. Thomas' Hospital with a cough, but did not think he had inflammation of the lungs; he had not been well since, although he had been able to keep at his employment, as hairdresser. Severe symptoms had only existed ten weeks before he died, and these consisted of pain in the chest, great dyspnœa, cough, occasional hæmoptysis, and latterly dropsy. He was sent to the Hospital as a case of phthisis complicated with heart disease (a very unusual combination), but the diagnosis was explicable. The left side of the chest was contracted, and almost immovable; it was dull on percussion, and cavernous respiration was heard, and the heart was drawn considerably more to the left than natural; there was great cough, but little expectora-

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tion; excessive dyspnœa, and an inability of the patient to lie on the healthy side. With this, the face was of a purple hue, the whole body was livid, the abdomen contained fluid, and the legs were anasarcous. Moreover, it was thought that a systolic bruit could be heard. These were his symptoms on admission, and afforded an explanation of the diagnosis which had been made. The man was relieved for a few days by the remedies administered, but afterwards the distress of breathing increased, the lividity became more marked, and purpuric spots appeared on the extremities. The body, after death, presented none of the appearances of one dead of phthisis, being not extremely wasted, but rather of pulmonary obstruction, indicated by the lividity, dropsy, and fulness and brightness of the eyes. There was serum in the right side of the chest, in the abdomen, and in the pericardium, as well as a nutmeg liver, a fibrinous clot in the spleen, and other appearances generally seen in pulmonary obstructions due to cardiac disease. The heart, however, was healthy, except a slight hypertrophy of the right ventricle. The right lung appeared enlarged, as it occupied the front of the chest, and was the only organ observable when the sternum was removed. The heart was drawn towards the left side, from the pericardium being firmly united to the pleura. The left lung was so firmly fixed to the chest that it had to be cut out, and it was then seen to be reduced in size to about that of its ordinary contracted condition. Upon making a section of it, it was found to be in that state known as cirrhosis, the greater part of its tissue being converted into a dense substance of the hardness of fibro-cartilage; this offered great resistance to the knife, and when cut presented a white smooth surface. The pleura, which in some places was nearly half an inch thick, was quite continuous with, and was composed of similar material to that which penetrated the lung. This was seen running throughout the organ, in the form of white tough patches of fibro-cellular tissue, interspersed with the dark colouring matter of the lung. About half of the bulk of the organ, however, was occupied by dilated tubes, and between them was this dense fibre tissue, mixed with the pigmentary matter of the lung. All the bronchial tubes were dilated and altered from their natural appearance, but especially

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those in the lower lobe. The healthy mucous membrane had disappeared, and thus in many places the tubes existed as mere membranous canals, with a number of valve-like transverse projections upon them. Towards the lower part of the lung they terminated in large round cavities, the latter lined by smooth membrane, continuous with the inner surface of the tube. The lung thus presented the appearance which is known as cirrhosis, consisting of enlarged bronchial tubes, with a dense tissue between them destroying the original structure of the organ; the left, and apparently healthy lung, contained a few small masses of strumous pneumonic deposit softening in their centre.

The principal interest in such a case is, I believe, in reference to phthisis, to which disease it unquestionably bears a very close relationship, and my opinion of its nature is shortly this:— In most cases of ordinary phthisis, which have run an average duration, two processes are seen, one being the deposition of a soft granular material into the air cells of the lungs, which varies in particular instances as to its true tubercular or inflammatory nature, and the other process being one of chronic inflammation; that the latter is not the result of a later stage of changes which may have gone on in the former material, when partaking of a pneumonic character, I will not altogether deny, but my belief is, that it is altogether a distinct process, differing in kind; that is, that the softer granular deposit seen in phthisical lungs is one thing, and that the dense tissue known as the consequence of chronic inflammation is another; that it is a process by which an organizable fibrin is formed in the parenchyma of the lung, and which goes on increasing, until the complete destruction of the organ is brought about. And such a process is seen to be intimately connected with a similar one going on in the pleura, whereby the latter becomes often of extreme density and thickness, and is joined to this new fibrous material which is eating its way into the lung. A similar result is sometimes seen from changes going on in an adherent pericardium, whereby a dense cellulo-fibrous tissue is slowly formed, and takes the place of the muscular tissue of the heart, which is as slowly consumed, or in a fibrous development in the endocardium, changing the structure of the muscular columns within the heart, or, as is sometimes seen

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in some forms of cirrhosis of the liver, where from a chronic peritonitis or capsulitis, a dense fibrous covering is formed around the liver, which, communicating with Glisson's capsule within, slowly increases in amount, until the organ at last becomes destroyed. In such cases there is no proof of the deposition of the ordinary products of acute inflammation preceding the more firm and dense fibre structure, but the latter tissue seems to be at once, though slowly, formed, constituting a chronic process from the commencement; so in the lung there is no proof against the statement that the more dense tissue, known as the result of chronic inflammation, is not altogether a primary and chronic process. In the majority of phthisical lungs, however, two conditions are seen, one of dense, hard, smooth tissue, uniting generally with a thickened pleura, and having dilated bronchial tubes running through it, and the other of soft, recent tubercular, or tuberculo-inflammatory material; but as occasionally we may meet with cases of acute phthisis running their course in five or six weeks, where the symptoms are severe, but the physical signs few, owing to a scattered deposit filling both lungs, so on the other hand we may meet with cases of chronic phthisis, which last as many years as the other form may weeks, where the symptoms are slight; but owing to the local changes going on in one part of the lung only, the physical signs are extremely well marked. Since, then, it is the exceptional case to meet with simple tuberculous deposit affecting the lungs without other changes, so it is the exceptional case to meet with the chronic inflammatory state destroying one lung without other evidence of tuberculous disease. As, however, the two are combined in most cases of phthisis, they cannot, even if met with separately, be considered independent of each other, and must be studied in the same connection, and, therefore, although the distinct term cirrhosis may be given to the disease under consideration, yet its relations with phthisis are so intimate, that we think it is erroneous to place it, as some authors do, under the heading of diseases of the bronchial tubes, the dilatation of the latter being altogether secondary, and due to the contraction of the intervening tissue, as Corrigan has long ago shown. It may be said on the other hand that phthisis is a constitutional

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disease, and although it may show its effects principally on the lungs, yet this is not necessarily so, and, therefore, to place other affections of the lungs under such a designation, is erroneous; but of late phthisis has been considered as synonymous with disorganisation of the lungs, produced by processes which are still under discussion, and which are, to a certain degree, tubercular and constitutional, and to a certain degree, local and inflammatory, and, therefore, if one of these conditions in its purity may be classed under phthisis, so may the other; and since cases of acute phthisis, or acute tubercular deposition in the lungs, may produce symptoms, which shall, by a mistaken diagnosis, be so unlike ordinary phthisis, as to be called fever, so may a chronic inflammation produce such an obstruction to the circulation that a condition similar to cardiac dropsy may ensue.

I believe, therefore, that cirrhosis is merely an extreme of a morbid condition, such as is every day seen, in a less degree, in phthisical lungs, and must be studied in relation with phthisis; the point of practical and scientific interest being, how far such chronic inflammation may be altogether a distinct process, or how far it is merely the result of changes in the more ordinary soft material seen in the recent deposits of phthisical lungs, but undergoing these changes from some constitutional cause which removes the deposit as far as possible from the unorganizable, or tuberculous forms: or, whether, indeed, sometimes the disease may not be set up by an ordinary pleuro-pneumonia. It would appear that sometimes such an inflammation is the first step in the production of phthisis (being the inverse of what generally happens, the inflammatory changes following the tubercular), and that a pneumonia may set up a phthisical process; and it appears also to be believed, by some, that a chronic pleurisy may end in such changes as we have been describing under the term cirrhosis; we believe, however, with Laennec, that the result of an empyema, or contraction of the pleura, is a carnified lung, and that cirrhosis is a chronic change of the pulmonic tissue, and has an intimate connection with phthisis.

Dr. S. Wilks, *18th of November*, 1856.

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3. *Constriction of the Right Bronchus.*

C. H., æt. 32, died in Guy's Hospital in October, 1856. He was a very dissipated, intemperate man, and stated that he had had venereal complaints several times, and had taken much mercury. He was in a very cachectic condition, and had long suffered from laryngitis: being on the point of suffocation, tracheotomy was performed, the house surgeon having previously listened to the chest, but having heard nothing indicative of the disease exhibited in the present specimen owing to so little air entering the glottis. The patient died a week afterwards from acute inflammation of the whole of the air passages, and also from chronic disease of the liver and kidneys. The top of the larynx was much swollen, altered in shape, and suppurating, but the cartilages were unaffected. The right bronchus just above its division into the secondary branches, was constricted to rather less than half its usual calibre; this constriction was not equal all around, but was caused by the falling in of the sides and back part. A careful examination was made to discover if the contraction was due to any external pressure, but none was discoverable, the only unusual appearance being a small quantity of dense fibrous tissue around the part, as if an inflammatory action had once existed there; there was also a partial loss of the cartilaginous ring at the seat of contraction, and thus the tube could be bent double. The bronchus was dilated below the affected part.

The interest of the specimen had reference to the cause of the contraction, and to the question whether this might be due to syphilis. Those foreign pathologists who speak of syphilitic bronchitis, phthisis, meningitis, hepatitis, arteritis, &c., would very probably have at once seen, in an affection like the present, the effect of a syphilitic ulcer. In the absence, however, of all proof of such ever having existed, the contraction may with more probability be attributed to the expulsion of a strumous bronchial gland in early infancy, causing a destruction of part of the walls of the tube, and leading to the constriction here seen. At the same time, the frequent occurrence, not only of laryngeal affections, but of bronchitis and phthisis, in those states of cachexia induced by syphilis, demand that more close observation should

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be made with reference to the morbid anatomy of the organs affected, to discover if there be any peculiar condition attributable to this cause. Dr. S. WILKS, 18*th of November*, 1856.

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4. *Large Encephaloid Tumour from the Posterior Mediastinum, causing death by pressure on the Œsophagus. Disease of the Lung.*

A laundress, æt. 55, twice married, with family by her first husband only. Her mother had six children, and died in childbirth: her father lived to the age of 70 years, and was subject to rheumatism. None of her relations, as far as she knows, have died from cancer. She has been accustomed to work hard, and has suffered from pain occasionally, at the epigastrium, caused, she thinks, by pressure against the ironing-board.

About seven years ago she was salivated for what appears to have been inflammation of the bowels. The salivation was severe, and long continued, and she has never felt so well since this occurred as she formerly did.

Early in June, 1856, she first noticed that there was something the matter with her chest. "A wheezing noise in the throat" appears to have first attracted her attention, followed by considerable expectoration. Soon after this, symptoms of dysphagia appeared, which came on in the following manner:—at first, a mouthful of food seemed to be arrested somewhere about midway in the chest, and this was coughed up, together with "some phlegm." This rejection of food would perhaps occur only once in the course of two or three days. At the beginning of August she was under medical treatment for what was considered to be pneumonia of the right lung, for which she was cupped, blistered, salivated, and finally sent, for change of air, into Cambridgeshire, where she remained for a month. During her residence in the country, she gradually became much worse; the appetite failed, the cough increased and became very troublesome, and the dysphagia increased to such an extent that she could seldom swallow any solid food, and very little fluid nourishment seems to have entered the stomach. She returned to London much reduced in flesh and strength, and first came under my notice on the 24th of October, 1856.

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Her general condition at this time was that of extreme exhaustion; complexion dusky and sallow; countenance anxious and expressive of great suffering; skin dry and chilly; pulse very small, and hardly perceptible—about one hundred and eighteen per minute; tongue coated with a creamy fur. She was too exhausted at this time, to allow of a complete examination of the chest being made; air was found, however, to enter freely the upper portions of both lungs. Pressure at the epigastrium caused much pain. There was troublesome cough, with occasional attacks of dyspnœa, which came on chiefly after attempts to swallow. The deglutition was so obstructed that scarcely anything she tried to swallow appeared to pass into the stomach. On two or three occasions, however, I succeeded in ascertaining that small portions of boiled rabbit and fowl, which had been taken, were retained, having apparently succeeded in overcoming the obstacle, to their descent into the stomach: when this occurred, no subsequent inconvenience, or desire to vomit, was occasioned by their presence in the stomach. It was, however, very rarely that any, especially solid food, entered the stomach, and when it did so, it appeared to be the result, as it were, of acoident, rather than of any effort which the patient herself seemed to be capable of making to accomplish deglutition. No nausea or pain was caused by the passage downwards, and the temporary arrest of the food or drink taken: it was commonly rejected after a very short interval, almost without effort, and apparently unchanged in character: milk, on these occasions, came up uncurdled. The bowels were costive. The urine was scanty, clear when passed, of a mahogany colour, and acid reaction, presenting only a trace of albumen on boiling—under the microscope, it presented numerous crystals of uric acid; blood-globules, yellow and brown pigment matter, and epithelium. The treatment consisted of small doses of mercury in the first instance, which had the effect apparently of removing the furred condition of the tongue: hydrocyanic acid, and subsequently opiates. Nutritious enemata, consisting of beef broth with cod-liver oil, were administered three times a day. Throughout the illness the patient suffered from great thirst, and an almost constant desire for food, with a feeling of being, as she expressed it, "starved to death." For two weeks before death she scarcely

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obtained any sleep, even from strong opiate injections. This sleeplessness was attended with extreme restlessness, and inability to remain in one position for more than a few minutes. She died from exhaustion on the 25th of November, 1856, about five months after the first symptoms of dysphagia had made their appearance.

*Post-mortem examination.**—Twenty-six hours after death. The abdominal parietes presented, on section, a layer of fat about one inch thick. The muscles throughout the body appeared to be much reduced in size, but not paler than natural.

Chest.—The pericardium contained about one ounce and a half of pale claret-coloured serum, free from clot. The heart and left lung were apparently healthy. Left pleura slightly adherent in parts; right pleura completely so; the adhesions over the lower lobe of the lung on this side being very firm and dense. The upper portion of the right lung appeared healthy, its lower lobe was completely hepatized.

Occupying the posterior of the mediastinum, was a large, irregularly defined, nodulated tumour, bounded above by the bifurcation of the trachea; in front by the heart and pericardium, the posterior part of the pericardium being adherent to, and intimately blended with, the anterior surface of the tumour; behind, by the œsophagus, and to the left by the aorta, which though considerably displaced by the tumour, had suffered no compression, but, on the contrary, appeared to be slightly dilated. The intercostal arteries, four or five of which were traced into and partly through the tumour, shewed no diminution of calibre.

The tumour presented, on section through its centre, a tolerably firm, fibroid structure, of a delicately brown, or pinkish-white colour, which grated against the knife in cutting. Towards the surface, and especially in the more superficial nodules, the structure was different, consisting of large thick-walled cysts, enclosing a delicate cellular network, and filled with a glutinous, lactescent juice. Under the microscope the firmer part of the tumour was found to consist essentially of moderate-sized cells, mostly ovoid in form, and containing one, two, and in some rare

* For many valuable suggestions relative to the treatment of the case during life, as well as for assistance in the *post-mortem* examination, I am indebted to Drs. Quain and Hare, who attended the patient jointly with me.

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instances, three small nuclei: the majority of these cells appeared however, to have only one nucleus: intersecting irregularly this cellular structure, were fine fibres, with some small blood-vessels. The more fluid part of the tumour, taken from one of the superficial nodules, presented, under the microscope, in addition to the above mentioned, moderate-sized ovoid cells, large oval, well-defined, compound cells; and the blood-vessels ramifying through this structure, were far more numerous than in the firmer part of the tumour.

On the upper part of the tumour, between the superior vena cava and the trachea, was a mass of enlarged bronchial glands, which exhibited, on section, various transition stages, from simple enlargement into black masses, streaked here and there with the characteristic pinkish morbid deposit, up to complete conversion into tumours, possessing the same appearance as the large mediastinal one, from which all black pigmentary deposit had disappeared. In one particular instance this was extremely well shewn, where the blackened tissue of the gland, with its envelope, formed a thick case, enclosing a pale, pinkish-brown, and softly fibrous mass, identical in appearance with some of the nodules belonging to the mediastinal tumour itself.

The œsophagus was found to come into relation with the tumour opposite the bifurcation of the trachea, and to be connected with, and partly embedded in the morbid mass for four inches and a half of its course. It emerged from the lower end of the tumour, about two inches above the cardiac orifice. Except where it was in immediate relation with the tumour, the œsophagus presented no alteration in form or appearance. My fore-finger was, with some slight difficulty, passed through every part of the œsophagus, even where it was most closely embedded in the tumour. On section, the mucous membrane was found to be entire, pale above, and at the part where the pressure had been greatest, and below this slightly injected as far as the cardiac orifice.

The vena azygos, which bounded, as it were, the tumour laterally and above, was closely bound down to it, by what might be regarded as the fibrous investment of the tumour itself. The interior of this vein, to the extent of two inches, was filled, and

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in parts distended with an enlongated mass, similar in appearance to the firmer portion of the tumour. This intra-venous deposit was found to extend to within one inch of the opening of the vena azygos into the superior cava. It was closely adherent to, and to some extent blended with the structure of the vein itself, but had not, apparently, penetrated its parietes.

The condition of the vagus nerves was peculiar. The right vagus entered the upper part of the tumour, and soon became completely embedded in it to the extent of two inches and a half, The nerve throughout this part of its course presented a remarkable fusiform enlargement. The left vagus presented a similar condition; its entrance into the tumour, and its coincident enlargement commenced at three quarters of an inch below the part where the recurrent nerve was given off. Under the microscope, this bulbous enlargement was found to consist of a basis of coarse granular matter, with irregularly scattered fine fibres of fibrous tissue, and a few nerve fibres, which were very sparingly distributed through the mass.

The trunk and branches of the vagus nerves above the fusiform enlargement were examined with extreme care, but without any apparent morbid alteration of structure being detected. Several branches of the vagus nerves on each side were traced through the tumour, and especially two long branches, deeply seated in the tumour, and crossing it from the trunk of the nerve, immediately above the tumour to the root of the right lung. The aortic and pulmonary plexuses, and branches of the sympathetic nerve were also carefully examined, and traced as far as possible; in some instances the latter were found to be deeply embedded in the mass of diseased glands, situated at the upper part of the tumour; but no abnormal condition was discovered in any of them.

The lining membrane of the trachea, and of the bronchi, as far as the root of the lung on each side was somewhat injected, but not otherwise altered in character. The larger divisions of the right bronchus distributed to the lower lobes of the right lung were found, on section, to contain some irregular masses of a soft, pale, pinkish-brown deposit, closely adherent to the lining membrane of the air tubes, especially in the intervals between the

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cartilages. They appeared to be blended with the morbid mass, in which the root of this lung was embedded, and which encroached upon its upper and middle lobes, without, however, causing any apparent condensation of the pulmonary tissue.

Abdomen.—The mucous membrane of the stomach was somewhat injected, and covered with a yellowish glairy mucus. Liver large; softer than natural; not otherwise apparently diseased. Other abdominal viscera tolerably healthy.

Remarks.—The case may be regarded as one of peculiar interest in reference to the function of the lower portions of the vagus nerves, and capable of illustrating the effects which would probably follow section of these nerves below the place of departure of the pulmonary branches, supposing that such an operation could be performed, without disturbing the functions of other organs not directly connected with the lower cut portions of these nerves. The bulbous enlargement of the vagus nerves, appeared to be analogous to the condition of the cut extremities of nerves in stumps some time subsequent to amputation, and he was inclined to consider, that both the pathological condition of the nerves in these cases, and the causes which led to the enlargement, were closely related; and this opinion seemed to derive additional support from the fact that in each case the bulbous enlargement of the nerves was accompanied by the phenomenon of referred sensation, the intensity and persistence of which he had found to correspond with the extent of the enlargement in the nerves. That pressure on the nerves could not, in this case, have been the cause of the enlargement, was evident from the circumstance that other nerves more deeply seated in the tumour, and consequently subjected to a greater amount of pressure, presented no apparent alteration in bulk. For these reasons the bulbous enlargement of the vagus nerves may be looked upon as essentially connected with the prolonged suspension of the functions of the stomach, and to have occurred in obedience to the law of reflex action.

The condition of the vena azygos was also a point of considerable interest in connection with the pathology of the present case, but it was not to be looked upon as unusual in these cases of

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tumours in the posterior mediastinum. I have met with a similar affection of this vein, in a case of secondary osteoid tumour * in the posterior mediastinum, which I am inclined, with Mr. Paget, to regard as a variety of encephaloid tumour, and there are other examples on record, in which not only the vena azygos, but the superior cava, and other neighbouring veins had been invaded by, or had shared in the disease. Whilst the venous system was thus prone to assume the disease, the arterial appeared to enjoy a complete immunity from it; and, as in the present case, where the arteries were embedded in the tumour, there was not, in consequence, any diminution in their calibre, nor, so far as I am aware, had any of the morbid deposit been found in their interior.

Dr. QUAIN for MR. SEDGWICK, *2nd of December*, 1856.

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5. *Phthisis.—Vomica communicating with several Bronchial Tubes.*

W. W., æt. 25, Leather Cutter. Has had indifferent health three or four years. Had pleurisy two years and a half ago, on the left side, and there was then suspicion of phthisis. Had frequently had slight hæmoptysis before he was first seen by me, on the 27th of November, 1855. He had then most of the general symptoms of phthisis. The left side of the chest appeared a little flattened, and the movements were much less free at the upper part than on the right side. From the fifth rib upwards, on this side, the resonance was much diminished, though the loud blowing sounds, and very distinct splashing, often accompanied by a metallic ring, which was heard when he coughed, left no doubt that a cavity of considerable size communicating with a bronchial tube existed at this part. The lower part of the left side was also more dull than the right, but breath sounds could be heard there. The expectoration was copious, and was described as frequently coming up in great gushes. In seven weeks he left the Hospital much improved in health, but there was no alteration in the state of the chest.

He remained in a delicate state of health, occasionally doing a

* Medico-Chirurg. Review for July, 1855.

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little, until the 1st of November, 1856, when he was very suddenly attacked, in the morning, whilst at work, with severe pain in the side, great dyspnœa and palpitation, and became pallid, cold, and prostrate. I saw him on the 3rd. Respirations sixty, very short and laboured. Pulse about one hundred and sixty. Very severe pain in left side of chest, loins, and abdomen. Profuse perspiration and pallor. It was impossible to percuss the left side on account of the pain; but no breath sounds could be heard below the fourth rib, whilst above it a very loud blowing sound was heard, accompanied by a distinct splash. Between this time and his death, these sounds were sometimes heard very distinctly, and at others they were entirely absent. Two days later, when there was less pain, I found good resonance as low as the fourth rib on the left side: but below that point complete dulness.

He died on November 7th.

A tubercular cavity was found in the apex and numerous small tubercles were scattered throughout the right lung.

The left pleura contained about a pint and a half of thick yellow purulent fluid. The left lung was small, collapsed, and airless. It was firmly attached to the upper part of the parietes as low as the second or third rib, also along the spine from the apex to the base, and to the space existing between the spine and root of the lung; and the pleural effusion had so compressed it, that its free surface formed a kind of irregular arch between the ribs and the mediastinum.

The parietes of the cavity, including the diaphragm, the ribs below the third, the free surface of the lung, and the space between the root of the lung and the sternum, was covered by a thick layer of recent yellowish lymph. The membrane below was considerably thickened, and appeared to have been the seat of old standing disease.

In the apex of the collapsed lung was found a cavity, holding two or three ounces of dirty flaky pus, but it was sufficiently large to contain two ordinary sized fists: it was irregular, crossed by bands and imperfect septa, and its parietes were thin, so that many portions of it were separated from the pleural cavity by not more than one or two lines. The ulcerated extremities of two or three largish bronchial tubes were found opening into the tuber-

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cular cavity; but no communication between the vomica and pleural cavity could be detected.

The lung was airless, and contained numerous miliary tubercles and small cavities.

There was a good deal of old standing disease in the larynx.

Dr. Barker, 16*th of December*, 1856.

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6. *Gangrenous Abscess of the Lung.*

The abscess occupied the ordinary seat in the majority of such cases, the lower lobe of the right lung and the periphery, rather than the central portion of that organ. The specimen was removed from the body of a middle-aged man of delicate constitution and cachetic appearance. He had been under treatment nearly a year, with symptoms of emphysema. About ten days before his death he was seized, without premonition, with symptoms of pleuro-pneumonia of the right lung, of low intensity, his constitutional state being that of marked adynamia. Nearly coincident with the local symptoms profuse expectoration occurred, of somewhat viscid, albuminous sputa, of almost milky whiteness, amounting to nearly a pint in the twenty-four hours, and of so offensive a character, that the attendants could hardly remain in the room. On a physical examination of the chest, about three days subsequent to the attack, obvious dulness existed over the middle and lower right antero-lateral portions of the chest, and a large mucous rale was heard during inspiration. The patient rapidly sank, without further change.

Upon examining the body, the left lung was found unadherent, large, distended, extending beyond the median line, and covering the superficial area of the heart. No *post-mortem* stasis existed, even at its root. The right lung also free and distended above, was strongly adherent to the costal pleura at its middle and lower portions, by old and recent adhesions. In detaching the lung at this situation the outer wall of the abscess gave way, and about two table spoonfuls of dirty-grey pus escaped. The cavity was, perhaps, large enough to admit a pigeon's egg; it was lined by false membrane, hanging, in parts, in dark discoloured shreds. The parenchyma was extensively solidified

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around the abscess, particularly above. Neither the pus, nor the walls of the cavity participated in the excessive fetidity of the expectoration. No effusion was found in either pleural sac. The heart appeared congested; its walls were of very dark colour and readily torn; the right chambers contained dark grumous blood; and a small, decolourized, unadherent plug extended from the right auricle into the pulmonary artery.

Dr. Cockle, *6th of January*, 1857.

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7. *Large Encephaloid Mass surrounding the Root of the Left Lung. Extensive Pleural Effusion.*

The mass, which was about the size and shape of a large cocoa nut, flattened, was situated between the root of the left lung and the heart. In its aspect it greatly resembled brain tissue, but was more resistant to the touch, and more gritty to the knife. It yielded a copious cream-like juice. The microscope shewed its structure to be composed of well-formed, variously shaped poly-nucleated cells, of granular matter, of many compound granular or "mulberry-like cells," of a delicate stroma, forming variously shaped interspaces, and of numerous blood-vessels.

The tumour compressed the bronchus, and all the blood-vessels of the lung. It had passed into the lung tissue, forming there several masses, varying in size from a pea to a small egg; some of which projected above the level of the investing pleura. The left pleural cavity contained about three or four pints of blood-tinted serum. This was clearly the result of the pressure of the tumour on the blood-vessels at the root of the lung, for there was no evidence save of slight pleurisy, and this was confined to a portion of the surface of the diaphragm.

The other organs of the body were healthy. There was somerough white deposit on the visceral pericardium, the results of a former pericarditis. There was no glandular enlargement anywhere.

The specimen had been taken from a warehouseman, æt. 27, who was admitted into the Brompton Hospital, under Dr. Quain's care, (Dr. John Sibbald, the reporter of the case, being clinical assistant), on the 8th of December, 1856. He dated his last illness from a slight febrile attack, which occurred six months previously,

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and which left him in possession of a short dry cough. Three months ago he observed his breathing becoming shorter, his appetite, his strength, and flesh to fail. His cough increased, and he expectorated with difficulty a tenacious glairy mucus, but never blood. In this state he was admitted into the Hospital. His sallow, cachectic, sorrowful expression, was remarked, and it was observed that he could lie in any position, but he coughed most when on his back. There were no other peculiarities worth noticing. An examination of the chest shewed the right lung to be healthy; over the whole of the left side there was marked dulness. The mobility was greatly diminished. The left side was by half an inch fuller than the opposite. There was feeble bronchial breathing over the apex of this lung before and behind. There was also feeble breath sound, audible at the base behind, but not in front. The heart was but little displaced. Over it there was a distinct, but limited friction sound, and in certain positions of the patient there was also a pleural friction sound. After a short stay in the Hospital the signs of effusion increased; the heart became much displaced towards the right side; the respiratory and friction sounds disappeared, and there was now heard with the first sound of the heart an endocardial murmur. The patient's weight increased by two pounds, an increase probably due to the increased effusion into the pleura. Blisters, mild mercurials, and iodide of potassium, were administered without material influence. The subject of tapping the chest was debated in consultation, but the conviction that solidification of the lung as well as effusion existed, forbad the idea. The symptoms got worse rapidly on the 17th of January, and he died on the 19th. The breathing over the apex of the lung was observed by Dr. Sibbald at this time to be of a more bronchial and metallic character than previously.

This case was of especial interest in connection with a specimen of like disease presented by Dr. Quain at a former meeting during the present session.* The tumour, in that instance, was not a sixth part of the size of the present specimen, but being situate a few inches nearer the median line, it pressed on the œsophagus, the aorta, and the bronchus, giving, by obstructing

Vide p. 36.

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the functions of these canals, most unmistakeable signs of its presence, and finally producing death by starvation.

Dr. QUAIN, *20th of January*, 1857.

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8. *Great Enlargement of the Heart, without Valvular Disease.*

C. G., æt. 45, was admitted, under Dr. Wilks' care, into Guy's Hospital, on the 19th of December, 1856, and died on the 21st of January, 1857. He stated that the only illness from which he had suffered was one twenty years before, when he swelled all over, (acute albuminuria?) but that he had been in good health since. About three months before admission, having begun to grow fat, he found he had difficulty in breathing, and some oppression at the chest. These symptoms continued until swelling of the legs came on, and he was taken into the Hospital with all the signs of cardiac disease. There was dropsy, with enlarged liver, slight yellowness of the skin, hæmoptysis, and pulmonary apoplexy; and on listening to the heart, the sounds were found to be very obscure; but on close attention, the first sound was perceived to be double, producing, with the diastolic sound, altogether, what is known as the triple beat of the heart. The urine was albuminous.

The *post-mortem* examination discovered hardening of the viscera, healthy kidneys, (the albuminous urine having been due to congestion), nutmeg liver, apoplexy and splenization of the lungs, &c. The heart was found to be very much enlarged, weighing twenty-six ounces; its form, however, was natural, as the due proportion was kept between the several parts. All the cavities were much enlarged, and the walls hypertrophied. The valves were quite healthy. The mitral orifice might have been slightly larger than natural, but if so, it merely partook of the general increase in the size of the left ventricle. The coronary arteries were excessively diseased, as were also the vessels of a corresponding size throughout the body, although not to the same extent. The muscular tissue of the heart was, in parts, slightly degenerated.

This case appeared to be one of those exceptional instances of heart-disease, where no affection of the valves is found; and

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although only one example has been recorded in the "Transactions," this cannot be taken as a measure of the rarity of this form of cardiac malady; for although by far less frequent than ordinary cases of valvular disease, yet it is by no means uncommon: some of the largest hearts met with being of this kind. No positive conclusion has yet been come to with reference to their pathology, but in the present instance, taking the case upon its own merits, an efficient cause may, we think, be found, in the diseased condition of the blood-vessels, and thus the same influence be considered in operation as is effectual in the production of enlargement in ordinary cases: that is,—an obstruction in the arterial system; this obstruction, however, being at the periphery of the blood-vessels, instead of at the trunk.

Dr. Wilks, *3rd of February*, 1857.

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9. *Gangrene of Lungs. Old Disease of the Cæcum.*

D. M., a pot-boy, æt. 35, was admitted into St. Thomas's, under my care, on the 28th of October, 1856. He stated, that eighteen years ago, he was a sailor in the India Company's service, and was invalided in consequence of a wound in the shoulder; that for the last thirteen years, he had been a pot-boy, and in the habit of drinking freely; that about eleven years ago, he was attacked with hæmoptysis, and in a week brought up more than a pailful (?) of blood: and that since that time he had been subject to occasional cough in cold weather, but had had no return of the hæmorrhage.

His present illness began about ten days before admission, with cough, expectoration, and violent pain in the left side. On admission, he was apparently suffering from a slight attack of pneumonia. The lower half of the left lung behind, though not absolutely dull, was duller than the corresponding part of the right lung, and its respiratory sounds were feeble, and mixed with a little small crepitation and rhonchus. Under the treatment that was adopted, he manifestly improved for the first two or three weeks of his stay in the Hospital; yet the improvement was far less rapid and satisfactory than might naturally have been expected, as regards both the local phenomena and the general symp-

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toms. From the end of this time his health continued for a short time stationary, and then began slowly and gradually to decline. He became more feeble and emaciated; his cough, which had, to some extent, disappeared, began to get troublesome again: the expectoration increased in quantity, and assumed the appearance of prune-juice, and acquired a fetid odour. On the 18th of December the following notes were taken:—"He is getting weaker and more emaciated, and the cough is incessant. He expectorated during the night nearly a pint of frothy prune-juice-coloured fluid, which yields a disgustingly fetid odour; and his breath, especially when he coughs, yieldsthe same kind of smell, in an even more intense degree. Skin warm; pulse one hundred and four, very feeble; tongue clean; appetite bad; no thirst; sleeps badly. The right side of the chest is resonant throughout; the breath sounds are rather harsh, and now and then a little rhonchus can be heard. The lower half of the left lung behind and laterally is dull, and vocal fremitus is well marked over the dull region. Over a surface equal in size to the hand, and a little above the extreme base, there is a very indistinct and feeble respiratory murmur, and on careful listening, a blowing sound can be distinctly recognised, both with expiration and inspiration, and bronchophony, approaching in character to ægophony, is audible. Over the rest of the lower half of the lung, the breath sounds are simply very feeble. The upper half of the left lung is resonant, and in the same condition as the corresponding part of the right lung. The heart occupies its usual position, and its sounds are healthy." He continued in much the same state, but becoming weaker, until the 18th of January, when he died. The only change worthy of notice being, that during the last few days, the whole of the left side became completely dull, and yielded a variety of bronchial sounds, and that rhonchus and crepitation became distinctly localised in some parts of the right lung.

Post-mortem examination.—Much emaciated. Right pleura healthy. The right lung was large, and for the most part crepitant. Its upper lobe was somewhat œdematous; its lower lobe highly so. In the posterior part of the lower lobe was a gangrenous cavity as large as a hazel-nut, which was surrounded by a broad rim of soft, dark-greenish coloured lung tissue; and in another part of the same

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lobe was a soft solid mass of greenish lung tissue, nearly as large as a pigeon's egg. The left lung was very firmly adherent throughout, and the adhesions covering the lower lobe were exceedingly thick and dense. The upper lobe of the lung was large, and airless, and solid throughout. It was smooth on section, had a dirty greenish hue, and a certain degree of translucency, and yielded a little transparent greenish fluid on pressure. In its apex, but for the most part at some distance from its surface, was an irregular gangrenous cavity, as large as a Spanish chestnut, which was lined by and contained a quantity of soft, opaque, yellow substance—evidently lung tissue in a gangrenous condition. The lower lobe was small and collapsed, and presented a cavity of irregular form, but altogether about as large as a duck's egg. The lower part of this cavity was lined, for the most part, by a thickish fibroid layer, adherent to which, here and there, were patches of sloughy tissue; connected with it, were two or three diverticula, extending in different directions, which were apparently comparatively recent formations, and of which the parietes were formed of sloughy tissue. This series of cavities occupied the lower and posterior half of the lobe: the remaining half being in much the same condition as the upper lobe. Pericardium and heart healthy.

All the abdominal viscera were healthy, except the lower part of the ileum and commencement of the colon. The lower part of the ileum was considerably dilated, and its muscular tissue thickened. Immediately above the ileo-cæcal valve, were two or three irregular patches, from the size of half-a-crown downwards, in which the mucous membrane was thin, and which were surrounded by irregularly contracted margins. Immediately below the ileo-cæcal valve, which formed merely an irregularly thickened rim, the large intestine, for two inches of its length, was contracted so that its internal circumference measured only three-quarters of an inch. The mucous membrane of this part was thickened and cicatrix-like. The muscular coat was thickened; in its upper half being straight, in its lower half, plicated. The two coats were separated from one another to a considerable extent, especially above, where they were half an inch apart; and the interval was occupied by fibrous tissue. There was also a considerable

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quantity of fibrous deposit external to the muscular tunic. Immediately beyond the contracted portion, the colon assumed its normal dimensions, but the mucous membrane was diseased in the first two inches of its course. It presented a cicatrizing ulcerating surface, the margins of which were thickened, sinuous, and contained, here and there, deposits of what looked like tubercular matter. The floor of the ulcer was white and fibroid, and encroached on by patches of mucous membrane. Two or three smaller, and apparently cicatrizing ulcers, were discovered in other parts of the large intestine, and the margins of these also were studded with (apparently) tubercular deposit.

Remarks.—The above case furnishes a good example of gangrene of the lung supervening on pneumonia; and a good example also, of stricture of the commencement of the large intestine from ulceration of the mucous membrane, which appears to have exerted no appreciable influence on the functions of the bowels. There are one or two points connected with these phenomena which are of some interest. In the first place, it would appear that shortly before death, gangrenous inflammation had attacked two or three portions of each lung; and that a disease, which was, in the first instance, local and accidental, had brought about a condition of the system which was favourable to its reproduction in other parts, —a peculiarity which would appear to be not very uncommon in cases of gangrene, no matter in what part the gangrene has originated. In the second place, the history of hæmoptysis seems to indicate, that at one period the patient was labouring under incipient phthisis; and as the appearances presented by the large intestines render it not improbable that they had been the seat of tubercular ulceration, there is hence an additional reason for supposing that at one period tubercles had been deposited in his lungs. Yet no tubercles were found at the *post-mortem*, and no traces of tubercle. Is it possible that the remains of this deposit can have been involved in some of the gangrenous patches; that the deposits themselves can have determined the situation of the gangrene?

Dr. J. S. Bristowe, *3rd of February*, 1857.

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10. *Pneumothorax and Empyema in which the Impulse of the Heart occasioned Metallic Resonance in the Pleural Cavity.*

A mason's labourer, æt. 25, was admitted into St. George's Hospital, having been ill two months. Three weeks previous to his admission he was suddenly seized with violent pain in the left side of the chest. He fell down with the intensity of the pain, which lasted for three quarters of an hour. In some degree the pain continued until he came under my care. On examination, there was want of breathing, and increased resonance on percussion all over the left side. A metallic sound was produced with each respiration, and when he spoke or coughed, succussion caused a metallic splashing sound. At the apex of the right lung there was dulness and some moist sounds. There was diarrhœa, excessive perspiration whenever he slept, and emaciation. The heart's sounds were healthy; and, when admitted, the heart was not displaced to the right of the sternum.

Eight days after his admission, on listening to the back of the left side of the chest, a distinct metallic sound was heard, which accompanied each impulse of the heart. It was most evident when he first sat up in bed; when he remained in this position for some minutes it ceased to be heard. The sound was found to disappear, also, when he laid down in bed, and it again became distinct when he sat up. It was louder in this part of the chest than it was behind. The pulse varied from one hundred and four to one hundred and forty-four. Daily, for nearly three weeks, this sound was found to be synchronous with the action of the heart. Gradually, during this time, the impulse of the heart was found to pass distinctly to the right of the sternum, and before the patient's death, which took place about a month after his admission, the heart was entirely to the right of the sternum. The day previous to his death, a metallic sound accompanied both the systole and diastole of the heart. It was heard when he was lying in the recumbent position.

On opening the cavity of the thorax, on the left side, a quantity of air rushed out of the pleural cavity with a hissing sound; and, at the same time, there was manifest collapse of the parietes of the chest on that side. The cavity contained

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five pints, by measure, of thick creamy pus. The whole of the pleura, covering the lung, and lining the cavity, was covered with thick lymph, and the cavity was partially subdivided into an upper and lower compartment by very firm adhesion of the margin of the lung to the outer side of the chest. The lung itself was much collapsed; upon the outer surface, near the apex, there was a small opening, sufficiently large to admit the end of a probe. This led into a small vomicæ which was about half an inch from the surface of the lung. Into this cavity, about the size of a hazel-nut, a small bronchial tube was traced. Tubercles and vomicæ were found at the apex of the right lung, the pleural surface of which was adherent to the interior surface of the chest. The heart and its valves were healthy. The liver was harder than natural, and coarse in substance. The other viscera were healthy. Dr. Bence Jones, *3rd of February*, 1857.

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11. *The Lungs and Heart of a Child, whose Death was apparently caused by a Metastasis of Suppuration.*

The subject of these specimens was a stout boy, æt. 3, who came under Dr. Balman's notice for an abscess situated in the neck, about one inch and a half from the angle of the left jaw, a little anterior to the sterno-mastoid muscles. When opened it gave exit to a considerable quantity of healthy pus. A counter opening was required on the third day. On the tenth day the child was well. On the day following, he had some shortness of breathing, which continued for three or four days, the attack being described by the friends as resembling asthma. He had also some difficulty in swallowing liquids, but not solids; in fact, he eat bread and butter for his breakfast a few hours before his death. This event occurred so suddenly that Dr. Balman, who had not seen the child during these days, on coming immediately that he was sent for, found him dead.

A *post-mortem* examination showed the sac of the abscess still existing, the lining membrane being of a dirty-brownish aspect, but containing no matter, and having no communication with any organ. The œsophagus and the larynx were found perfectly healthy. When the trachea was laid open a thick coating of

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puriform matter was seen extending downwards as far as the division of the bronchi, where there was a rather greater accumulation. The left bronchus, as far as it could be followed through its ramifications, was filled with the same creamy-looking matter. The right bronchus presented no such appearances, and the lung-tissue appeared alike healthy on both sides, except the oozing of matter from the small bronchi of the left side. There were no coagula in either the pulmonary arteries or veins. The heart was healthy, save that there were but two (still efficient) aortic valves.

Dr. Balman remarks, that the interest of the case centered in the connection which manifestly existed between the healing of the abscess in the neck and the presence of a quantity of purulent matter in the air-tubes of one of the lungs. This matter, which appeared to be independent of true inflammatory action (and which, in reply to a question, was said not at all to resemble coagulated lymph), was manifestly the cause of the child's death, by producing a suffocative spasm.

Dr. Quain for Dr. Balman, *17th of February*, 1857.

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12. *Intra-Thoracic Cancer.*

The patient was a married woman, æt. 26, of tolerably healthy family. She had felt pain in the lower part of the left side, occasionally, since her marriage five years ago. There is reason to believe that a blow was received on the side about this period. At Christmas she became seriously indisposed. The symptoms and physical signs in the early and mid-stages of the disease were those of relapsing pleurisy, with copious, and possibly circumscribed effusion. Marked increase, by measurement, existed over the left mammary region, but since, here, tenderness and a liquid impulse, during cough, existed, these signs were mistaken by me, and regarded as making a tendency to the production of an empyema of necessity. It was only after an exploratory practice had been unsuccessfully made, together with the appearance of an external tumour in the left axillary region, that the diagnosis of malignant growth appeared certain. Extensive anarsarca of the lower extremities, with effusion into the

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peritoneum, gradually occurred, and death, apparently by asthenia, followed in the latter end of December.

Post-mortem examination.—A general tendency to decomposition was observed. Upon opening the thorax, a large tripartite mass was seen, exceeding, in aggregate bulk, an adult head, and of so semi-fluid a consistence that, in detaching it from its connections, large quantities of grumous blood and encephaloid matter escaped. The portions of the mass were invested with a fine bounding membrane of a glistening character. The larger rounded portion occupied nearly the entire left side of the chest, crushing the lung along the vertebral column, and adhering to its anterior face. Firm adhesions existed on this side throughout, particularly between the tumour, spine, and raised portions of the fourth, fifth, and sixth ribs, which latter were markedly softened, and formed a medium of connection between the tumour and the oblong swelling upon the outer chest wall. The tumour had carried the heart before it as far as the right nipple, but did not, itself, extend far beyond the right costal cartilages. By this encroachment, however, together with that of the displaced heart, the right lung also was lessened in volume to the extent of, at least, one half, and bound down by adhesions. The second portion of the tumour, of the size of an orange, nearly separate from the larger mass, lay behind the manubrium sterni; and a still smaller portion, of the shape of a fig, was situate below the xiphoid cartilage. The heart was normal in size and structure. Considerable effusion existed in the peritoneal cavity. The liver, spleen, &c., were natural.

Microscopic examination revealed the characteristic elements of malignant growth.

Dr. John Cockle, *17th of February*, 1857.

13.—*Cretaceous Masses Expectorated by a Person in good health.*

The patient was a female, æt. 35, an out-patient, under the care of Dr. Peacock, at St. Thomas's Hospital. She stated that four years before, she had a slight cough, and, at the end of three or four days, spat up a small piece of "stone." The cough then left her, and she continued free from any symptoms

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of affection of the chest, till about a month before the time at which she applied to Dr. Peacock. She then again suffered from cough, which was hard and dry, and unattended by any expectoration. After three weeks she brought up some small pieces of stone, but without any blood, and with very little mucus.

When first seen by Dr. Peacock she had not expectorated any pieces for two days, but she brought six small cretaceous masses which she had coughed up, and complained of the cough, which, especially troubled her at night, and said she felt as if there were other pieces in her throat. She stated that she had generally enjoyed good health, and had never been ill, except with scarlet fever during childhood; but being at an early period of pregnancy, was rather thinner than usual. She was somewhat pale, but appeared in good health. Her voice was slightly husky, and she said she had occasionally lost it. Her complexion was fair, and she had a strumous aspect. The chest was well developed, but rather flat beneath the clavicles, and especially on the left side. The respiratory sounds were generally feeble, but became sufficiently loud on forced inspiration. There was no rhonchus or morbid sign.

The following week she brought three other small calculous masses which she had coughed up. There was a slight tinge of blood at the time of their expectoration, but no mucus. A week after she was again seen; she had not expectorated any more of the pieces of chalky matter. The cough had entirely left her, and she regarded herself as in her usual health. The pieces of cretaceous matter expectorated varied in size, from one which was about four lines in diameter, or about the size of a bean and nearly quadrangular in shape, to a piece somewhat larger than a large pin's head, and several were evidently fragments of larger masses (Fig. 4). They had irregular forms, and a chalky appear-

FIG. 4.

Represents three of the larger pieces of the natural size.

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ance, and indeed exactly resembled the small masses which are frequently found in the lungs and which are occasionally expectorated by phthisical persons. Dr. Peacock was, however, of opinion that they were probably expectorated, not from the lungs, but from bronchial glands which had been tuberculous in early life. DR. PEACOCK, *3rd of March*, 1857.

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14. *Dysenteric Ulceration in connection with acute Pneumonia.*

The specimens, which illustrated the fourth case in the appended tables, were exhibited before the Pathological Society, in order to give myself the opportunity of drawing the attention of its members to a phenomenon, which I have not infrequently found accompanying cases of acute pneumonia, and one which, I have reason to believe, is something more than a mere accidental complication. I allude to the occurrence, in connection with that disease, of a slight dysenteric affection of the large intestine.

I shall divide the following paper into three parts:—in the first, I shall describe that abnormal condition of the intestine to which I refer; in the second, I shall examine the evidence on which the connection between it and the pulmonary affection is assumed; and, in the third, I shall discuss the nature of the relationship existing between them.

Description of Diseased Intestine.—The disease appears to be confined to the mucous membrane of the large intestine. It occurs in small patches, which are sometimes stellate, generally irregular, yet have a tendency to take a transverse direction. They seem to occupy usually the projecting portions of the mucous membrane, are scattered somewhat unequally over its surface, but at the same time are generally more advanced and more abundant towards one extremity of the large intestine, than towards the other. In their earliest condition, they present an area of congestion more or less intense, and sometimes spotty, in the centre of which is an irregular, thin, buff-coloured patch of lymph, which is pretty firmly adherent to the mucous membrane, yet on removal leaves a whole surface beneath. In a somewhat more advanced stage, the patch of lymph is larger and thicker and somewhat granular, the mucous membrane around is

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more deeply congested, the whole of the affected portion has become more or less tumid, and on removing the lymph the surface beneath is generally found slightly excoriated. In the most advanced condition which I have yet recognised, in connection with pneumonia, the patch has separated, a shallow ulcer of irregular shape has formed, and the mucous membrane around, though still inflamed, has become less congested and less tumid than it was. In some cases, it has seemed as though fresh false membranes were in process of formation upon the excoriated surface.

Under the microscope, the patches of lymph appear to consist chiefly of ill-formed or breaking-down corpuscles (having a considerable resemblance to the nuclei of the intestinal epithelium), mixed with a certain amount of amorphous granular matter and indistinct fibrillæ. A vertical section shows plainly that the crust is continuous with the follicular contents, which are more abundant and less perfect than natural, and approximate in character to the false membrane to which they are attached; on squeezing the section, the false membrane may sometimes be seen to recede from the basement membrane, and to carry with it more or less perfect cylindrical casts of the follicles. The only abnormal conditions, presented by the inter-follicular tissue, are tumefaction and intense uniform congestion; the latter, in some cases at least, being evidently due to extravasation.

The morbid process would appear, therefore, to be one of local inflammation, accompanied by an increased, but imperfect formation of epithelium. And the description I have given, so far as I am aware, is that of neither a very rare nor very peculiar form of disease; it is, I believe, the description of dysenteric ulceration in an early and mild form.

Proof of Connection between the Pulmonary and the Intestinal Affection.—For the purposes of this inquiry, I have availed myself of those *post-mortem* examinations, which have been recorded, (chiefly by myself) at St. Thomas's Hospital, between the beginning of October, 1853, and the day on which that case was examined, which furnished the specimens brought before the Society. They amount to six hundred and twenty.

From an examination of them, it appears that, exclusive of

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all examples of consolidation from simple pulmonary collapse, and all examples of simple carnification, there were forty-nine in which pneumonia was either expressly stated, or proved by the description, to have been present. But in three the intestines were not opened; and, as in consequence of this omission, they are rendered valueless so far as regards the present enquiry, the number of cases of pneumonia to be analyzed is reduced to forty-six.

Now, a glance at the table (A) shews that, in eleven out of this number, or in a rather smaller proportion than one in four, there was ulceration of the large intestine. But this proportion is obtained by classifying together so many incongruous elements that, though suggestive, it really expresses a fact of no scientific value.

In the first place, the character of the ulceration varied; in three instances it was typhoid, in connection with typhoid fever; in one it was distinctly tubercular, arising in the course of phthisis; in one example it was dysenteric, but of long standing, and was associated with phthisis which was probably, and pneumonia which was certainly, secondary to the intestinal affection; and in six cases only, was it of the kind described at the commencement of this paper. So that in truth, not more than one in eight of the recorded cases of pneumonia, presented acute dysenteric ulceration of the colon.

In the second place, the nature of the lung-affection varied; in nine instances it was the intercurrent pneumonia of fever; in six cases the inflammation of the lung supervened on phthisis, in six on chronic heart and kidney disease, and in two on wasting surgical complaints; in one instance it was developed during the last hours of a man dying of supra-renal cancer; in another, it crept on towards the close of a case of paraplegia; and, in a third, it originated just prior to death in a victim of empyema; in one case it was secondary to Asiatic cholera, in one to diabetes, in one to scarlet fever, and in one to measles; and in the remaining sixteen cases, it was ideopathic and acute. The first thirty cases (though differing among themselves in respect of extent and intensity of disease, and in many other particulars) were alike in this,—they were all examples of secondary pneumonia; and acute

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dysenteric ulceration existed in two only of the number, or at the rate of one in fifteen. The last sixteen cases were, without exception, I believe, examples of acute and primary pneumonia; and acute disease of the large intestine was present in four of them, or at the rate of one in four.

It appears, therefore, that on taking, indiscriminately, all cases of pneumonia, acute dysentery was found to co-exist with the lung-disease in one case out of eight—a proportion sufficiently large, I think, to attract attention, and to suggest some connection between the two affections. But it appears further, that, on dividing the cases of pneumonia into two classes, the primary and the secondary, (a division which is no less important than it is natural) the dysenteric affection was found to complicate the former class in so much larger a proportion than it did the latter, that while it is rendered likely that there is nothing more than an accidental connection between the secondary form of pneumonia and the intestinal disease, the probability that there is some important relationship between pneumonia in an acute form, and the dysenteric affection, becomes proportionately enhanced.

But it might be objected that three or four of the cases, which I have tabulated as acute pneumonia, were really examples of the secondary form of the disease. I need scarcely, however, discuss the grounds on the mature consideration of which I classified the cases alluded to under this head; since, on reference to the table, it will be seen that the only ones to which it is possible to take exception, are those numbered 12, 13, 14, 15, and 16, and that by excluding these, the relative frequency of the co-existence of dysentery and acute pneumonia would be greatly increased, and my position strengthened in an equal degree. Again, it might be objected that some of the cases which I have called secondary pneumonia, were, really cases of the acute form of the disease; and in truth, this objection has some show of reason in its favour; for it is far from improbable that patients, while labouring under other diseases, may occasionally be exposed to such influences as would tend to produce acute inflammatory attacks, and it is clear that an acute affection thus produced, though secondary in point of time, would be essentially a primary disease. Now, I have no hesita-

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tion in asserting, that the great majority of the thirty cases which I have called secondary pneumonia, were essentially what I have stated them to be. With regard to a very few, however, there may be a little room for doubt; and I may remark, that it was only after very careful consideration of the facts of each, that I determined to place three or four cases, as I have done, in the class of acute pneumonia, and to classify several others under the head of secondary pneumonia. I may add, further, that whatever claims the latter few cases of which I speak had to be called acute, were shared equally by the two cases of secondary pneumonia which were accompanied by acute dysentery; and that the classification of these as acute cases, would only tend to confirm the view which I have been led to entertain. Indeed, although I have not felt justified in including these cases among those of acute pneumonia, from the fear that I might be bending facts to meet my own views, I am by no means sure that they do not really belong to that class. Of the two accompanied by dysentery I have given the details (cases 17 and 18, table A).

But the mere coincidence, however common, of dysenteric ulceration with acute pneumonia proves nothing, unless it can be shewn, at the same time, that the coincidence between dysenteric ulceration and other diseases is comparatively rare. Let us pursue this enquiry. A further analysis of the six hundred and twenty cases that furnished materials for the former part of the argument, shows that, exclusive of cases of malignant disease, there were eighty in which the large intestine was found to be distinctly ulcerated, or in a state approaching to ulceration. Forty-eight of this number were cases in which the ulceration was tubercular, and associated with phthisis or general tuberculosis; and ten were examples of equally well-marked typhoid ulceration, occurring in connection with typhoid fever; in two cases the ulcers were of old date, had cicatrized and produced stricture; in two, the ulcers were of a chronic form, also, but were secondary to long-continued constipation, and accompanied by dilatation and hypertrophy of the intestine; and in four the ulceration was dysenteric, but far advanced and of long standing. In fourteen cases the intestinal affection was more or less acute, and had more or less claim to be regarded as dysenteric;

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to the examination of these only, therefore, our attention need be directed (table B).

In two of these fourteen cases, the patients died of renal disease with anasarca; in one (11) it is stated that two or three small ulcers were found in the cæcum, in the other (10) it is recorded that one or two ulcers, covered by prominent dark-coloured sloughs, were discovered in the sigmoid flexure. In two cases, the intestinal affection was very extensive, and associated with phthisis; in one of them (14) the patient was a sailor, who had been abroad, and had laboured for a considerable period under hepatic abscesses; in the other (9) the patient died of empyema, which had probably been produced by the perforation of a vomica. In one instance (7) the patient had laboured under cirrhosis of the liver and ascites, of which he was supposed to have died; and in another (18) the disease occurred in a female, who died of cancer of the pylorus. In two cases the disease was manifestly acute and severe, and was, I believe, primary idiopathic dysentery, though associated in the one case (12) with acute peritonitis, and in the other (13) with intense congestion of the lungs and kidneys. In the remaining six cases, the affection was slight, and occurred in connection with extensive pneumonia; and in four, if not all of these, the pneumonia, as before explained, was acute and idiopathic.

Hence, it would appear from the *post-mortem* records, that after excluding all cases of undoubted cancerous, tubercular and typhoid ulceration, together with all those in which the ulceration was chronic and of remote origin, there remain fourteen cases only which furnish examples of what may be called acute dysentery, and that in six out of those the intestinal affection was associated with extensive pneumonic consolidation,—a fact all the more remarkable, when it is borne in mind how small is the proportion of cases of pneumonia to the total number of cases examined in the dead house. A more critical scrutiny, however, of these fourteen cases will, I think, shew that the connection between the two diseases is even more intimate than might be supposed from the statements just made. For, although I have reckoned all the cases as examples of acute dysenteric ulceration, it is by no means clear that all are classed under this head with equal justice; thus

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cases (10 and 11) from their local character, and case (14) from its severity, and the peculiar features which it presented, are scarcely entitled to be placed in the same class with the majority of the other cases. And since my design has been to shew merely, that pneumonia is frequently complicated by dysentery, and not to disprove the existence (which every one admits,) of acute ideopathic dysentery, I might with almost equal fairness exclude cases (12 and 13) from the list. The exclusion of these, while diminishing materially the number of cases among which comparisons are to be instituted, leaves untouched all those which were associated with pneumonia; and consequently greatly increases the proportion which cases of the latter class bear to the total number of cases, and, in an equal degree, enhances the probability of the truth of that inference which I have ventured to draw.

I believe the foregoing analyses shew, that acute dysenteric ulceration occurs not infrequently, in connection with pneumonic consolidation; and that, in proportion to the number of cases recorded of each form of the disease, it is so much more frequently associated with acute pneumonia, than it is with secondary pneumonia, that, considering the difficulty which not infrequently exists of distinguishing the one form of the pulmonary affection from the other, it becomes exceedingly probable, that it is connected, not so much with mere inflammation of the lungs, as it is with that disease which we term acute pneumonia. I have shewn, also, that acute dysenteric ulceration is comparatively rarely observed, and that it is found associated with pneumonia very much more frequently than could possibly have been the case, had the complication been merely an accidental one. I may add, that there are two or three considerations, which tend to strengthen the view I have taken. The first is, that the intestinal disease was as nearly as possible in the same degree, and to the same extent, in all the cases of pneumonia in which it was discovered; whereas, if the notes of the condition of the intestines in the other cases be carefully perused, it will be found that nearly all differed in one or more particulars among themselves, and differed equally from the group connected with inflammation of the lungs. The second is, that on examining the *post-mortem* records from April, 1850, to October, 1853, (most

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of which were made by myself) I find not more than twelve cases in which there was acute primary pneumonia, and in which the intestines were examined; and of these (while two were complicated with pericarditis, one with meningitis, and one with heart disease) two presented that form of colic ulceration which I have described above. The last is furnished by a case, published by Mr. J. Gamgee, in the last Volume of our "Transactions," p. 398, in which the same connection which I have sought to establish between pneumonia and dysentery was incidentally shewn to obtain in the case of an old horse affected with pneumonia.

Nature of Connection between Pneumonia and the Dysenteric Affection.—It remains for me now to explain, so far as I am able, the nature of the relationship which I believe to exist between pneumonia and dysenteric ulceration. That it is not accidental I think I have already succeeded in shewing; and that the dysentery is the cause of the pneumonia is an idea too absurd to be entertained for a moment. There are three other alternatives, however, which suggests themselves to me, each of which deserves more or less consideration; first, is the intestinal affection the result of the treatment adopted; second, is the intestinal affection caused by the pulmonary disease; or third, do both affections originate independently of one another, but from the same cause?

1st. When my attention was first directed to this subject, I thought it possible that the remedies employed might have had some influence in producing the intestinal disease, more especially as I knew that the patients were treated for this disease at St. Thomas's Hospital on a tolerably uniform system, and that antimony and mercury were pretty generally the chief remedial agents employed. Knowing the irritant properties of antimony locally applied, I thought it possible, though unacquainted with any evidence in support of my surmise, that the administration of that drug extended over a period of some days might exert an irritant effect on the colic mucous membrane; and again, I thought it not impossible that the persistence in a course of mercurial treatment, might, under certain circumstances, be the immediate cause of intestinal disease. It is not worth while to enter upon

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the numerous objections which offer themselves to these suggestions; it is sufficient to point out, that an examination of table (A) will shew, that neither antimony nor mercury were given in every one of the cases of pneumonia complicated by dysentery, and that, therefore, neither of these remedies could have been the cause of the latter affection.

2nd. That the dysenteric ulceration is secondary to the pneumonia, and the result of it, is a view that has some shew of reason in its favour; for the dysenteric affection appears always to have been slight, compared with the pulmonary disease, and such as to suggest at once its secondary and dependent origin. I am not aware, however, of any other fact corroborative of this view. I do not know that there is any special functional relation between the lungs and the intestinal mucous membrane, which could account for it; and though I do not deny the plausibility of this explanation, I must say, it has no strong evidence in its favour, and I could only consent to adopt it in the absence of any more probable suggestion.

3rd. The last alternative is the one which I am disposed to embrace. I believe that the lung-affection and the intestinal affection are related to one another, in the sense that they both originate from the same cause—that exposure to cold or wet, or that influence, whatever it was, which produced the pneumonia, produced at the same time the intestinal disease. It is well known, that those adverse conditions, which, in one case, will induce inflammation of the lungs, in another will excite peritonitis, in another acute dysentery, in another hepatitis, and in another acute inflammation of the kidneys; and indeed, that there is no organ in which acute inflammation may not be caused through the operation of one and the same agent. Now, it is quite clear that the local internal inflammation which succeeds on exposure to atmospheric influences, to cold, wet, or whatever it may be, is not produced by the direct application of the exciting cause, but that it is preceded in each case by some general disturbance of the system, to which the local disease is immediately due; and there is manifestly, no reason, why that cause, which in so many different individuals will produce inflammation of so many different organs, may not excite inflammation

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of more than one organ in the same individual. An examination of the tabulated cases will bear out, to some extent, the notion here expressed. Thus, in two of the cases of pneumonia, pericarditis co-existed with the pulmonary disease; and in one case, pneumonia was associated with croup; in one instance, acute peritonitis and acute dysentery were present in the same person; and in another, acute dysentery was associated with intense congestion (probably inflammation) of the lungs, and intense congestion of the kidneys. Illustrations of the principles above indicated might easily be multiplied, but I have brought forward sufficient, I believe, to demonstrate its truth, and its sufficiency to explain the not infrequent co-existence of pneumonia and dysentery. The explanation which I offer, is not only a simple and a natural one, but it is one of wide applicability; it meets the conditions of the cases which form the ground-work of this paper; it would hold good for any case that might arise, in which the intestinal and pulmonary affections should be more equally balanced; and it would equally hold good for other cases in which the dysenteric affection, though combined with, is out of proportion to the pulmonary disease—it prepares us, in point of fact, to understand, that cases of acute dysentery may be accompanied by more or less acute lung-disease, and applies, therefore, to case (13), already adverted to.

The same explanation may, and, I suspect, does apply to the occurrence of jaundice in connection with pneumonia. That this symptom, dependent, of course, on some hepatic derangement, is a frequent concomitant of acute pneumonia, is a well-known fact, and one that is illustrated in table (A). Some have endeavoured to explain it, by supposing that the inflammation is prolonged from the lung, through the diaphragm, to the liver; and some have suggested, that it is due to the physiological connexion existing between the two organs: I am sure that the former explanation is wrong; but the latter I am not in a position to disprove, although I suspect my own is nearer the truth.

I am inclined, with more boldness, perhaps, than discretion, to carry my views yet further, and to explain by means of them the connection existing between the dysenteric and hepatic diseases of hot climates. Dr. Budd ingeniously ascribes the hepatic

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abscesses occurring in these cases, to absorption of pus taking place at the ulcerated intestinal surface. He may be right, and perhaps, a more extensive acquaintance than I at present possess with these cases, in their acute and early form, might convince me of his correctness; but I feel bound to say, that I have never, during rather more than seven years in which I have conducted the medical autopsies at St. Thomas's, seen a case in which I had reason to believe that abscess in the liver was produced by ulceration of the intestines; yet my experience comprises a considerable number of cases of abscess of the liver, and a considerable number of dysenteric ulceration; and I cannot help thinking that the explanation I offer, if not more plausible, is, at all events, a reasonable one; and is the more probable that it serves to bring all the affections, above alluded to, into one class, and makes the nature of the connection between the diseases of the different organs simple and intelligible.

In conclusion, I may repeat, that my object in this paper, has been, to establish and explain the fact, that acute dysenteric ulceration is a not infrequent accompaniment of acute pneumonia; that it has as definite a connection with that disease as the jaundice and the labial herpetic eruption, which are so frequently recognised; and that the history of acute pneumonia is not complete without a reference to the intestinal lesion. The fact itself is, probably, of no great importance, and I am not quite sure that, under the explanation which I have given of it, its apparent proportions have not dwindled away into comparative insignificance; nevertheless, it will still be found to illustrate an important principle, and one that may often be usefully borne in mind: namely, that where acute inflammations are the result of the operation of general causes, the local manifestations are by no means necessarily confined to one organ.

Dr. Bristowe, *17th March*, 1857.

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TABLE A. *Analysis of Cases of Primary Pneumonia.*

No.	Sex.	Age.	Condition of Lungs.	Of Intestines.	Of other Organs.	History, Remarks, &c.
*1	F	20	Posterior half of upper lobe of right lung, and contiguous portions of lower lobe, covered by a thin film of recently deposited lymph. Surface of lung studded with minute extravasations of blood. Greater part of lower lobe intensely congested and nearly solid, though, for the most part, slightly crepitant. It broke down readily on pressure, and yielded a considerable quantity of bloody fluid. The cut surface closely resembled that of the spleen. The posterior half of the upper lobe was perfectly solid, slightly granular, of a pinkish-grey colour, broke down readily on pressure, and yielded a large quantity of purulent fluid. Some parts of this lobe were in the same condition as the lower lobe; but the anterior portion of the lobe, and the middle lobe, were in a tolerably healthy condition. Left pleura healthy. Left lung congested.	Dysenteric ulceration of colon.	Healthy.	Total duration of illness, thirteen days. Had all the symptoms of acute pneumonia; and was treated for that disease—at first with blisters, and calomel, and opium—during the last two or three days with wine, ammonia, æther, opium, &c. Case No. 1 in table B.
*2	M	28	Right pleura universally adherent. Adhesions about apex, and in one or two other situations, old and firm; but the remainder of the lung was enveloped, and attached to the thoracic parietes, by a layer of yellow and toughish, but recent lymph, varying from a line in thickness to a mere film. Right lung large, very heavy, and hepatized in nearly every part. It was granular on section, and had a light-pinkish, mottled appearance. It broke down readily on pressure, and yielded a tolerable quantity of thin, turbid, reddish, but not puriform	Dysenteric ulceration of colon.	Healthy.	Total duration of illness, six days; his symptoms were those of well marked pneumonia. He was cupped and blistered: had mercury and antimony administered internally, and strong mercurial ointment rubbed in upon the thighs. Case No. 2 in table B.

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No.	Sex.	Age.	Condition of Lungs.	Of Intestines.	Of other Organs.	History, Remarks, &c.
			fluid. The lower lobe of the left lung was solid, much congested, and in a state of splenization. Its surface was covered by a layer of recently deposited lymph. Many of the bronchial tubes of the right lung were filled with fibrinous casts.			
*3	M	29	Right lung large and heavy, and enveloped in a layer of elastic, yellowish, recent lymph. The whole of the upper and middle lobes, and the upper two-thirds of the lower lobe were solid. They were quite airless, granular on section, had a pale pinkish-yellow, mottled appearance, broke down readily on pressure, and yielded a small amount of slightly turbid fluid. The yellow hue appeared rather due to jaundice than to the stage of the inflammation, for the lung was decidedly not infiltrated with pus. Remaining portions of lower lobe congested, œdematous and sparely crepitant. The bronchial tubes contained fibrinous casts. The left lung was tolerably healthy.	Dysenteric ulceration of colon.	Liver large and slightly congested; but exceedingly yellow. No lymph on its surface. The bile in the gall ducts and bladder appeared to be healthy.	Total duration of illness four or five days. He laboured under the usual symptoms of acute pneumonia, and in the course of the disease became slightly jaundiced. Leeches were applied. For two days he took mercury, antimony and opium; during the last day he was treated with ammonia and æther. Case No. 3 in table B.
*4	M	55	Lower lobe of left lung large, heavy, and covered by a thick layer of yellow, soft, yet somewhat brittle lymph, of which a thin film extended over the lower half of the upper lobe. On section, the whole of the lower lobe was found to be solid and very soft; its surface was granular, and mottled with pale brick-red and pale yellow, and a large quantity of thick yellowish fluid oozed from the cut surface. In many places the tissue had begun to break down and form small cavities. That part of the upper lobe which was in contact with the lower	Dysenteric ulceration of colon.	Liver large, but mostly healthy. It presented, however, a considerable number of depressions, which corresponded to large cicatrix-like formations of fibroid tissue situated in its substance.	Total duration of illness ten days, the last two of which were passed in the Hospital. After drinking freely over night, he was attacked with severe headache, and pain between the shoulders; most severe when coughing or breathing deeply. A short, dry cough came on soon afterwards.

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No.	Sex.	Age.	Condition of Lungs.	Of Intestines.	Of other Organs.	History, Remarks, &c.
			one was far more solid than natural, lacerable, of a pale yellow colour, slightly crepitant, and yielded a thin, but slightly puriform fluid on pressure. The rest of the lung, and the whole of the right lung were healthy.			He had all the general symptoms of pneumonia; he had dulness, tubular breathing, and minute crepitation over the lower half of the left lung; and viscid, rusty-coloured expectoration. He was blistered and purged, and treated with antimony. Case No. 4 in table B
5	M	40	Pneumonia of both lungs, second and third stages; slight pleuritis.	Healthy.	Fatty and light yellow liver.	Ill three weeks; died on day of admission; jaundiced.
6	M		Pneumonia of both lungs, second stage; slight pleuritis.	Healthy.	Healthy.	Died on day of admission.
7	M	35	Pneumonia of both lungs, second stage; slight pleuritis.	Healthy.	Slight peri carditis; jaundiced liver.	Total duration of illness, thirteen days; jaundiced.
8	M	40	Pneumonia of right lung, second and third stages; slight pleuritis.	Healthy.	Healthy.	Total duration of illness, five days.
9	F	35	Pneumonia of left lung, second and third stages; slight pleuritis; bronchial casts.	Healthy.	Healthy.	Duration of illness, ten days.
10	M	31	Pneumonia of right lung, second stage; slight pleuritis.	Healthy.	Pericarditis.	Died on day of admission.
11	M	35	Pneumonia of right lung, second stage; slight pleuritis.	Healthy.	Healthy.	Ill only thirty-six hours.
12	M	34	Pneumonia in both lungs, second stage. A few tubercles in left apex.	Healthy.	Healthy.	In Hospital one week.
13	M	6	Pneumonia in both lungs, second stage; slight pleuritis; croup.	Healthy.	Healthy.	Ill one week, with symptoms of croup, for which disease he was treated.
14	M	25	Pneumonia in both lungs, second stage; no pleuritis.	Healthy.	Atrophied, granular, mottled, kidneys.	In Hospital one day; treated with blisters, mercury and antimony.

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No.	Sex.	Age.	Condition of Lungs.	Of Intestines.	Of other Organs.	History, Remarks, &c.
15	M	33	Pneumonia in right lung, third stage; slight pleuritis; bronchial casts.	Healthy.	Liver somewhat hob-nailed, and kidneys in an early stage of Bright's disease.	In Hospital five days.
16	M	65	Pneumonia in both lungs, second stage; no pleuritis.	Healthy.	Healthy.	Patient in Hospital nearly three months for chronic rheumatism. He was treated for rheumatism, and was apparently improving to within four or five days of his death.

TABLE A'. *Analysis of those Cases of Secondary Pneumonia which were combined with Ulceration of the Colon.*

*17	M	25	A few patches of recent lymph on the surface of both lungs. Right lung large and heavy; its upper and middle lobes were congested, œdematous, and in parts hepatized. In one place a solid patch, as large as a hazel-nut, was softened and infiltrated with pus, and was separated from the surrounding tissue by an abrupt fibrinous margin. The lower lobe was almost completely hepatized, and presented several patches of fibrinous deposit, from the size of a pea to that of a marble, all of which were softened in their centre, and filled with puriform fluid. The left lung was in much the same condition as the right.	Dysenteric ulceration of colon.	Healthy.	Patient labouring under diabetes; said to have been ill six months on admission; in hospital one month. Treated with quinine, cod-liver-oil, &c. Affection of lungs apparently overlooked. Case No. 5 in table B.

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No.	Sex.	Age.	Condition of Lungs.	Of Intestine.	Of other Organs.	History, Remarks, &c.
*18	F	Adt	Pleurae healthy. In upper part of right lung an irregular cavity, as large as a hen's egg, filled with dirty-looking pus, into which hung a slough of lung-tissue, about as large as a hazel-nut, attached to the walls by a sloughy peduncle. The walls of the cavity were abrupt, and a margin of fibrinous deposit separated it from the surrounding tissue. In posterior part of same lobe was a similar cavity of smaller size. Both were surrounded by red, solidified and lacerable lung-tissue. In upper part of lower lobe was a considerable quantity of congested, solidified tissue. Scattered throughout this part were several small cavities, with distinct fibrinous parietes, and numerous opaque yellowish lumps running more or less into one another, and varying in size from that of a pin's head to that of a bean. Although the yellowish deposits had many of the characters of tubercle, they resembled the congested tissues around in nearly every point but that of colour, so that it seems probable that they and the cavities should be looked on as the products of recent inflammation. Left lung in same condition as right, but disease in it less advanced.	Dysenteric ulceration of colon.	Partial atrophy of one kidney.	In Hospital three weeks; admitted for fever. A mercurial purge was administered on admission. She was treated with citrate of potash mixture, and subsequently with quinine. Bed sores formed. Case No. 6 in table B.
19	M	12	Miliary tubercles in lungs; pneumonia.	Tubercular ulcers in ileum and colon.	Tubercles in brain, peritoneum, spleen, and mesenteric glands.	Patient treated for cerebral disease.
20	M	18	Pneumonia, second and third stages, in lower lobe of left lung; commencing phthisis in apex of each lung.	Extensive dysenteric ulceration in colon; tubercular ulcer in ileum.	Healthy.	Patient ill about four months; supposed to be labouring under dysentery, and treated for it.

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No.	Sex.	Age.	Condition of Lungs.	Of Intestine.	Of other Organs.	History, Remarks, &c.
21	F	15	Pneumonia, second and third stages.	Cicatrizing typhoid ulcers in ileum and colon.	Healthy.	Ill of typhoid fever about five or six weeks.
22	F	12	Consolidation of lungs.	Typhoid ulcers in ileum and colon.	Healthy.	Typhoid fever. In Hospital one month.
23	F	14	Consolidation of lungs.	Typhoid ulcers in ileum and colon.	Healthy.	Typhoid fever. In Hospital rather more than two weeks.

Table B.

No.	Sex.	Age.	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
*1	F	20	The whole of the large intestine was very much congested, and its surface studded pretty thickly with yellowish, granular, adherent flakes, apparently of lymph. In the cæcum and ascending colon were numerous small ulcers from about a line to a quarter of an inch in diameter; they were oval or circular, shallow, and covered generally with thin, more or less adherent crusts of yellow lymph. Stomach and small intestines healthy.	Acute pneumonia.	Healthy.	This is the same case that is numbered 1 in table A.
*2	M	28	The large intestines presented numerous patches, apparently of ulceration, which varied from a line to a quarter of an inch in diameter; they were irre-	Acute pneumonia.	Healthy.	This is the same case that is numbered 2 in table A.

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No.	Sex.	Age.	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
			gular in shape, sending off processes in various directions. They were considerably elevated; and patches of soft, yellow, granular lymph were more or less strongly adherent to the surface of all of them. None presented any actual breach of surface. Under the microscope, the patches of lymph appeared to consist of a more or less amorphous, fibroid, granular material, interspersed with a greater or less number of ill-formed or breaking down corpuscles. The inflamed part of intestine, viewed from the surface (when denuded), presented pretty nearly the normal arrangement of parts. The mouths of the follicles appeared natural; their contents, if anything, increased in quantity; but the projecting ridges of mucous membrane between them were intensely red (apparently from extravasation rather than from simple congestion), tumid, and more prominent than usual. On a vertical section, the contents of the follicles, which certainly in many instances appeared healthy, were seen to be continuous and blended with the fibrinous layer on the surface; and on squeezing the section the fibrinous layer could be made to separate from the mucous membrane, taking with it the contents of many of the tubes. Stomach and small intestines healthy.			
*3	M	29	The mucous membrane of the colon presented numerous congested patches. Many of these were about as large as a split pea; others were of irregular shape and larger size, and generally extended transversely across the intestine, occupying chiefly the prominent ridges. On all these a small patch	Acute pneumonia.	Biliary congestion of liver; jaundice.	This is the same case that is numbered 3 in table A.

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No.	Sex.	Age.	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
			of greyish lymph was detected, which could be easily scraped away, exposing a congested and granular, but in no instance an ulcerated surface. Stomach and small intestines healthy.			
*4	M	55	In the cæcum, ascending and transverse colon, existed a good deal of dysenteric ulceration. Where the disease was least advanced, clusters of points of deep congestion existed around a small, elevated patch or streak, which appeared like a thin, but scarcely perceptible false membrane. In a more advanced stage, the patch of lymph had become larger and thicker, the congestion deeper, but less extensive (assuming the character of a ring), and the congested portion of membrane more tumid. In a yet further stage, the congestion had again become diffused, but it was more dusky, and the patch of lymph had wholly or partially separated, leaving a shallow, but distinct ulcer, on the surface of which another patch of the same kind had a tendency to form. The ulcers were irregular, but frequently elongated, or almost linear, and seemed chiefly to occupy the more prominent parts of the mucous membrane. Under the microscope, the false membrane appeared to consist of cells and nuclei which bore a close, if not exact, resemblance to those of the intestinal epithelium; and indeed, they appeared due essentially, to excessive formation and degeneration of the epithelium of the intestinal surface, including also, apparently that of the follicles. Stomach and small intestines healthy.	Acute pneumonia.	Cicatrix-like formations in substance of liver.	This is the same case that is numbered 4 in table A.
*5	M	25	Throughout the large intestine were numerous small superficial ulcers or excoriations, which were	Secondary pneumonia (?).	Healthy.	This is the same case that is numbered 17 in table A.

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No.	Sex.	Age.	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
			discoloured by fæces and situated on the prominent parts of the folds. Stomach and small intestines healthy.			
*6	F	Adt	The large intestines presented a considerable number of small circular excoriations, which were most abundant in the neighbourhood of the cæcum. Stomach and small intestines healthy.	Secondary pneumonia (?).	Partial atrophy of one kidney.	This is the same case that is numbered 18 in table A.
7	M	54	Much disease of large intestine, most advanced in ascending colon, diminishing towards rectum. The disease affected the projecting edges of the transverse folds, separating the intestinal pouches from one another. The diseased patches were exceedingly narrow, and between two inches and half an inch in length. In their earliest condition, they consisted of tumefaction and reddening only of the mucous membrane; in a more advanced stage the tumefaction was greater, the discolouration slate-coloured or reddish-brown, and the tumid portion had begun to assume the characters of a slough. In a yet more advanced stage the slough had ruptured, and a ragged-edged linear ulcer was produced.	Congestion and œdema of lungs.	Cirrhosis of liver; ascites.	Patient in Hospital rather more than five weeks; labouring under symptoms of liver-disease and ascites, of which he died.
8	F	52	Ileum, in greater part of its length, studded with flakes of lymph, for the most part circular. On scraping these off, the surface below was found to be swollen, granular and congested, but not ulcerated. A similar appearance was observed throughout the large intestines, but the flakes of lymph were generally larger.	Congestion of lungs.	Cancer of pyloric extremity of stomach.	Patient in Hospital sixteen days; supposed to have died of disease of stomach.
9	M	25	Mucous membrane of lower part of ileum congested, and small shreds and patches of lymph adherent to it. Same form of disease, only more ad-	Phthisis; empyema.	Healthy.	Patient under treatment for pleuritis three years ago, since which time he has had

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No.	Sex	Age.	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
			vanced, in cæcum and ascending colon. Mucous membrane variegated, at one part deeply congested, at another covered with patches of discoloured lymph, and at the other parts tumid, of a blackish hue, and apparently in a sloughy condition.			the symptoms of progressive phthisis; and subsequently of empyema, which was apparently produced by the opening of a vomica.
10	M	38	One or two ulcers in sigmoid flexure, covered by a prominent dark-coloured slough.	Œdema of lungs.	Contracted granular kidneys; old inflammation of liver.	Patient died of renal disease. In Hospital one week.
11	M	33	Two or three small ulcers in cæcum.		Mottled granular kidneys; hypertrophy of heart.	Patient died of kidney disease. In Hospital two weeks.
12	M	41	In the lower part of the ileum were several patches of deep congestion; one occupying about a foot of its length. The congestion in these places was very intense, and occupied both the serous and mucous surfaces, the parietes being somewhat thickened. The congested mucous membrane was covered by patches of buff-coloured, granular, adherent exudation. In many parts of the large intestine there were small patches of congestion and thickening of the mucous membrane, which appeared chiefly to occupy the projecting folds, and to extend transversely; most of these were covered by a little adherent exudation.	Healthy.	Recent peritonitis, with accumulation of puriform fluid in the pelvis. The congested portions of ileum were those bounding the pelvic abscess.	In Hospital one day; treated for peritonitis, with mercury, opium, and leeches In the paper I have classed this case as one of acute dysentery; it might just as well (some may think better) have been called acute peritonitis. The fact, however, is, that both forms of diseases existed, and were, I suspect, both produced from the same cause.
13	M	18	Mucous membrane of whole of large intestine intensely congested; all the prominent folds were covered by thin patches of adherent greyish lymph, the removal of which exposed the mucous surface below paler than the surrounding parts, usually white, but here and there excoriated. These patches, which appeared to be isolated in the beginning, had	Right lung much congested; the left presented numerous patches of pulmonary apoplexy; the sectional surface of which	Kidneys intensely congested; small extravasations of blood in sub-mucous tissue of urinary bladder. Deep congestion of liver; malformed, but competent aortic valves.	Patient in Hospital five days.

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No.	Sex.	Age	Condition of Intestines.	Of Lungs.	Of other Organs.	History, Remarks, &c.
14	M	40	coalesced in many parts, so as to form a kind of network. Cæcum, ascending colon, sigmoid flexure and rectum most diseased. Extensive ulceration of colon, most advanced in cæcum, and diminishing towards rectum. Ulcers thickly set, varying from a line to an inch in diameter, more or less circular; smaller ones consisted of a white, lenticular thickening of mucous membrane; larger ones presented a ring of white thickening, surrounding a slate-coloured patch, which was often in process of separation as a slough, and had sometimes been wholly removed, exposing the muscular coat.	varied from a square inch in area downwards. Tubercular cavities and tubercle in left lung. Empyema on right side.	Abscesses in liver; three were severally as large as the fist; peritonitis.	Patient, a sailor. In Hospital five months, but had been ill for some time previously. Died of complication of disorders.

Dr. Bristowe, 17*th of March*, 1857.

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15. *Ossific Deposits on the Larynx, Trachea and Bronchi.*

W. W., æt. 38, died in Guy's Hospital of phthisis, in the autumn of 1856. He had been suffering ten months from pulmonary symptoms, and nothing remarkable was observed about the case. The lungs were much disorganized, both by tuberculous deposit and chronic inflammation, and the intestines were ulcerated. The larynx, trachea, and bronchi presented a very remarkable appearance, owing to the whole mucous surface being covered with a number of small bony plates. These were in the greatest quantity on the anterior part of the trachea, and were developed within and beneath the mucous membrane. They were situated, for the most part, between the cartilaginous rings, of which they were quite independent; and being developed in the soft structures they could be readily moved. At the lower part of the trachea, they almost filled up the spaces between the rings, but above and below were more irregularly disposed. They were quite smooth, except at the bifurcation of the trachea, where a rock-like mass, growing from the cartilage protruded into the air passage. There was no ulceration and no disease of the laryngeal cartilages. The deposits were true bone, being composed of remarkably well formed osseous tissue.

Dr. Wilks, *17th of March*, 1857.

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16. *Case of Malignant Disease of the Larynx, supervening on common Sore Throat.*

The subject of the disease, a woman, æt. 51, in whom the catamenia had ceased eight years, stated that, with the exception of colds and sore throats, she had always enjoyed good health. Last June, seven months previous to her death, she was attacked by a very severe cold and sore throat, in which the tonsils were so swelled, that for three weeks she was unable to swallow solid food. After this she became hoarse, and two glandular swellings formed in the neck, one small and hard, near to the larynx, which was persistent; the other larger, softer, near to the root of the neck, which dissolved away. The sore throat and the enlarged tonsils went away, but the

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difficulty of swallowing, and some impediment to the breathing went on slowly increasing. When Dr. H. saw her, five months after the commencement of the disease, he found her much emaciated and weakened, her breathing was quick, and painful to witness, for both inspiration and expiration were accompanied by a harsh, shrill, croupy sound. She complained of great difficulty in swallowing, which altogether prevented the deglutition of solids, and made those of liquids very painful and suffocative. It also, sometimes, led to the desire to vomit, on which occasions, however, mucus only, and never food, was discharged. She had some little pain in the larynx, which she experienced most at night, and the part was a little tender to the touch. She spat up daily a large quantity of clear, jelly-like mucus, which had the appearance of liquid albumen, but which possessed such tenacity that forceps, unassisted by scissors, always failed to separate a particle of it for the microscope. After standing some days, a slight sediment of a creamy, curdy character formed in it, from which the clear supernatant fluid could be poured. Both these portions of the sputum, but especially the sedimental portion, exhibited, under the microscope, an abundance of large and small epithelial scales and cells; sometimes blood cells and pus globules, and constantly other cells, which, while they resembled, more or less, ordinary epithelial cells, were also extremely like the hastily and over developed forms, common to the different varieties of malignant growth (Fig. 5). The physical examination disclosed, in the mouth, the appearance only of injected faucial mucous membrane; being a very nervous woman, she could not bear the use of the spatula, nor could she permit the observer to pass his finger to the root of her tongue. The critical state of her breathing, and the easily-provoked fearful fits of suffocation, made it undesirable to press this part of the investigation.

The larynx itself, was observed to be somewhat enlarged and tuberculated.

The chest, extremely emaciated, was found by Dr. Sibson's chest measurer to move only moderately, and less on the left than on the right side. Percussion was normal all over the chest. The respiratory murmur was feeble, but natural. The

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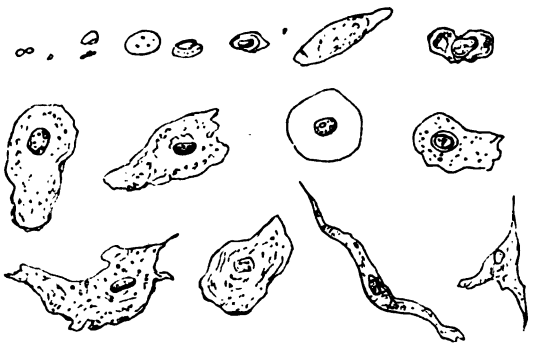
croupy respiration was heard loudest and most harshly over and near to the larynx. It was heard much less loudly in the

FIG. 5.



Represents the cells found in the sputa.

upper part of both sides of the chest, but somewhat louder on the right side than the left. The heart's sounds were natural. No other signs of disease were found.

The symptoms went on getting gradually more critical and distressing, until at the end of seven months from the commencement of the disease, she sunk, completely anæmiated.

The case was seen during life by Dr. Sibson, Dr. Cockle, and Mr. Bowman. The diagnosis was, of course, clear to each observer. The obstruction in the larynx was easily felt by the finger, when passed into the fauces under the influence of chloroform, a measure adopted at the recommendation of Mr. Bowman, to remove all doubt as to the impossibility of giving her surgical relief.

Dr. Sibson and Dr. Cockle gave their valuable assistance at the *post-mortem* examination. We were permitted to examine only the neck and chest, and the only important discovery we found to describe was in the larynx itself, the cavity of which was almost completely blocked up by a hard tumour about the size of a large filbert. It was situated in the right side of the larynx, in the upper part of its cavity, below the superior border

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of its ventricle, and below the epiglottis. Its structure was fused into the neighbouring tissues, especially those of the pharynx, comprehending the attachments of the superior and middle constrictors, so that the coats of the tube were thickened and matted together. An elliptical ulceration occupied the under surface of the epiglottis from about its middle down to a little below the ventricular orifice, engaging the inferior vocal cord. The tumour was also connected with the right ala of the thyroid and cricoid cartilages, so as to unite them into an inflexible mass. These cartilages, also, were at least twice their natural thickness, and cut with a gritty, horny feel.

In the microscopic examination of the tumour I must acknowledge the kind and valuable assistance of Dr. Brinton.

It possessed the gristly appearance and section of schirrus to the naked eye, but its cut surface exhibited, here and there, opaque friable points, almost close enough to suggest their being the interstices of a network formed by the more fibrous portion. Under the microscope these opaque points turned out to be composed of large aggregations of cells, compressed into irregular forms by close packing, and exhibiting appearances of a more or less complete degeneration of their contents. Many of them, however, still contained nuclei, and had elongated processes of great delicacy which appeared to unite with those of adjacent cells into a rudimentary fibrous network. The contents of these cell-masses were composed of ordinary fibrous cancer, mingled with the elements of the original areolar tissue, the yellow or elastic fibres being extremely distinct and natural.

The thickened and ossified cricoid cartilage was invested by a perichondrium, the tissues of which were interlaced with bony points, so that when stripped off from the subjacent mass, its inner surface sustained numerous little hard protuberances. The calcareous deposit was of two kinds:—a sparing amount of what seemed to be ordinary bony matter sprinkled throughout a cartilage, otherwise of normal structure; and an unorganized granular mass, which appeared to have been originally deposited in a fibrous tissue, and consisted almost exclusively of carbonate of lime.

The points of interest in this case, Dr. Hawkesley submits, are:—

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1st. The comparative rarity of malignant growths in this situation. Very many of the recorded cases are insufficiently precise to determine the true nature of the unnatural growth. C. H. Ehrmann, in his "Histoire des Polypes du Larynx," has collected together thirty-one cases, from the writings of twenty-three different authors; out of these, about three only, are undoubtedly cancerous, and five are possibly so. Trousseau and Belloc's case is included in the above. There is also, one recorded by Morgagni.

Rokitansky says, that cancer not unfrequently forms the basis of epithelial formations of the larynx. I have been unable to find any decidedly cancerous case recorded by English authors.

2nd. The peculiarities of the sputa, which gave additional probable evidence to the correct diagnosis at an early period of the disease, before the principal signs were developed.

3rd. Assuming the pre-existence of a cancerous dyscrasia of the blood, the evidence the case affords, that common catarrhal inflammation may determine for the cancerous disease the seat of its outbreak.

4th. The illustration it affords of the modifying power of tissue over the variety of cancer; for, at the mucous surface, its structure was that of epithelial cancer, deeper, and on the cartilage, it was that of fibrous and ossific cancer.

Dr. Hawkesley, 17*th of March*, 1857.

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17. *Expectoration of Portions of Hydatid Cysts; apparently the result of an Accident to the Patient.*

The patient, A. M., æt. 40, was of moderate stature, but delicate formation. She has, nevertheless, enjoyed excellent health, and was of a healthy family.

Eleven years ago she had scarlatina, and that is the only illness she remembers to have had besides the present one. She attributes the latter entirely to the following accident. About eleven months ago she lived in London, in the situation of lady's maid. One evening, when sitting at tea, her mistress suddenly called her; she rose precipitately, and this caused a morsel of bread, which was at the time in her mouth, "to go the wrong

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way," as she herself expressed it. A violent fit of coughing ensued, on recovering from which she was sent out on some business. Soon afterwards, being in an omnibus, she was seized with a choking sensation in the larynx, and so troublesome an itching along the spine, that she was obliged to rub it strongly. At this time there was little cough. She got home about five hours from the occurrence of the accident. Severe vomiting now ensued. During the night she slept well, but observed next day that she had perspired copiously, and that the left side of her face and right arm were covered by white blotches, "like blisters without water," the surrounding skin being of a deep red colour. A surgeon, who was called to see her, pronounced these to be nettle rash. She also suffered from pains in the limbs. Troublesome cough now came on, and she believes that from this cause she never slept during the five succeeding nights. The expectoration became thick, brown, and adhesive, and she had pain at the left side. During this time she was partially confined to her bed. In about ten days from the accident she had, however, recovered sufficiently to remove to Norfolk. She remained there about five months, and during all the time, especially at night, was much troubled by laryngeal irritation, cough, and copious perspiration. On returning to town in July last she became my patient.

About four months ago she first remarked that she expectorated something that closely resembled orange jelly; since then the same thing has occasionally occurred. On about four occasions she expectorated white substances, which alarmed her greatly, as "they rolled up like great worms." She twice observed a little blood with the sputa, but their general appearance was merely muco-purulent. There was no marked constitutional disturbance, but she had lost flesh considerably. Her cough, which was peculiar, consisting of three efforts, distressed her rather by constancy than severity. She complained of soreness of the left side of the thorax, and of a "pricking and shooting sensation" in the right side. Very careful examinations made on the 24th and 31st of October yielded the same results. On the left side, dulness on percussion, from beneath a line encircling the chest and touching the lower angles of the scapulæ. This dulness

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was very marked posteriorly; somewhat less so at the side, and still more modified anteriorly. The respiratory murmur was found to be impaired in a manner precisely corresponding to the dulness.

Bronchial respiration was not noticeable, but there was a well-marked inspiratory valve-like, or clicking sound, and it was most audible about the lower margin of the axillary space. The physical signs on the right side were normal. It is not desirable to give the treatment in detail.

It consisted at first of cod liver oil, and other tonics, with expectorants and sedatives. A blister was kept open on the affected side. Iodide of potassium with the external use of iodine was subsequently employed. I found, however, that none of these remedies were effective. The cough and orange-jelly-like expectoration, and that of white membranes continued. The latter was so abundant, that she assured me that on one occasion nearly a saucerful of membranes was brought up. It may here be mentioned, that although relief was experienced on expectorating the larger membranes, dyspnœa was not a prominent feature of the case.

At length, in February, 1855, fourteen months from the commencement of her illness, and about seven since the membraneous expectoration was first noticed, I determined on trying the effect of mercury. Salivation was therefore effected, and gently kept up for about ten days. I had the satisfaction to find that this treatment promised well almost immediately; cough and expectoration became notably diminished, and, subsequently, her general health appeared to have improved.

Soon afterwards, in consequence of having gone to the East, I lost sight of my patient. I had, however, an opportunity of again seeing and examining her on the 21st of January last. She then informed me that she had expectorated the "white skins" once only since her salivation, and the orange-jelly-like expectoration not at all. Nevertheless, some bronchial irritation long continued, and for this she remained under treatment. It consisted, mainly, of sedatives and tonics. At the date last referred to, she was free from all chest symptoms, and appeared in perfect health. The only physical signs

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remaining were slight dulness on percussion, and a low sound, having a friction-sound character, in the position in which the valve-like sound was previously observed. I have, very recently, ascertained that her health continues excellent.

It must, I presume, be accorded that a foreign body in the air passages, was, in this case, the exciting cause of the subsequent symptoms. It would appear that this body very soon passed from the larynx into the left lung. Distal irritation, *viz.*, vomiting, itching along the spine, and eruption on the skin resulted. Inflammation of the lung, itself, appears to have been next in succession, and after some time, the membraneous expectoration was noticed. Thus far the production of the membranes seems connected with direct irritation of the bronchi.

Very numerous examinations of the sputa yielded the following results:—

They were, at times, simply muco-purulent, but masses of some consistence, and of the size of small filberts, often occurred in them. These masses were found, under the microscope to consist of pus corpuscles, intermixed with numerous cells many times larger, and more doubtfully, of blood corpuscles, interwoven in a fibrillated stroma. The microscope proved that the bright yellow sputa, appropriately compared, by the patient, to orange-jelly, consisted of delicate membranes massed in folds, and studded with irregularly shaped patches of a bright yellow colour. The white membranes invariably presented a laminated structure. They consisted of thin pellucid layers, that could be separated by careful manipulation. When several of these layers were superposed and adherent, a compound membrane was formed of a pearly-white appearance, possessing both tenacity and elasticity. Some of these membranes were of a considerable size. One which I preserved measures two inches square, when spread out. As the shape of the membranes was usually that of tubular rolls, which, when being expectorated, would be liable to distortion, their rolling up, subsequently, was easily explained. Attached to the concave surfaces of the white membranes some of the thin yellow kind was occasionally found. In connection with the white membranes, I discovered some very remarkable microscopic appearances.

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My attention was first arrested by numerous combinations of round or ovoid granules, grouped in a manner suggestive of vegetable organization. The granules varied in size, from less than that of a blood corpuscle to many times larger. Rugged looking masses of still larger size were occasionally mixed with them, and both granules and masses varied in colour, from a yellowish to a dark brown. Occasionally, in the same field with them, the bright yellow material, previously spoken of, might be observed. The action of test liquids on all these bodies was very slight. The alkalies gave no result, neither did the mineral acids, with the exception of slight disintegration of the granular bodies. Iodine with acid had no effect on them; neither had boiling them in ether or alcohol. Oil globules were also seen in connection with the membranes. It appeared probable that the granular bodies, the brown and the bright yellow masses, had a common origin, and this origin I at length discovered. Dotting the convex portions of some of the white membranes, I noted certain dark brown isolated spots, the largest being visible to the naked eye. Under the microscope these spots were found to consist of bodies, and fragments of bodies, variously grouped, and presenting great variety in size and arrangement. The bodies varied from the size of a blood corpuscle, to more than ten times the diameter. They possessed no proper nuclei, but the appearance of one body being partly or wholly within the other was very constant.

In some instances several were thus involved together. In other cases, one body seemed to grow from the other. In a few, the arrangement of several flattened bodies, one upon the other, with a successive diminution of diameter, gave the appearance of a pyramid; usually, in proportion to the size, and, it might be supposed, of the age of the bodies, there was evidence of decadence. In some instances, in which one body appeared within the other, mere traces of splitting were seen. These traces commonly extended through the external body at right angles to it, stopping short of the internal body. In others the splitting was such as to afford a very exact resemblance to a Maltese cross. On the other hand, in some cases, detached fragments of an inner body were to be seen enclosed by an unbroken

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external body. It was most remarkable that in almost every instance of external rupture, the fragments were acted upon by a peculiar force; this had the effect of arranging them in rings around the parent bodies, and as the fragments appeared to have undergone further subdivisions, and to have been acted on by a similar force, a second ring, with a second clear space, was not infrequently seen surrounding the first ring. In some cases, too, the central rings were almost, in others entirely, void.

It was plain that the branchial arrangement of the granular bodies was produced by the operation of the force described; also, that they, and the larger masses, were derived from the rupture of the round or ovoid bodies. I have used the indefinite term body, in this description, for the following reasons. The term cell was inappropriate, on account of the absence of distinct cell walls. The external body appeared homogeneous as far as the commencement of the contained body, which being marked by a deeper shade of colour itself, appeared homogeneous. The bodies might be supposed to have been concretions in concentric layers, but there was a general evidence of organization which the term concretion does not express.

From what source were the bodies derived? Notwithstanding that they were so slightly acted upon by any test fluids, it appears to me more than probable that they originated in effused blood. The position of the bodies that were in the early stages, invariably on the outside of the membranes, or the part of them that had been in contact with the tissues of the body favours this idea.

The proneness of the colouring matter of the blood to alter the various shades of yellow, under certain circumstances, as well as the coalition of the blood cells themselves is well known. Now, in a few instances in the case before us, something like the union of single pairs of blood cells was observed. The coalition of many blood cells would account for the size of some of the bodies. But whether the bodies thus formed became (as frequently appeared to be the case) possessed of inherent powers of growth, or even of reproduction, I shall not offer an opinion. It is certain that the bodies passed through definite changes,

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apparently closely akin to those known to be the result of the organic force. As no similar phenomena, so far as I am aware, have been previously described, and as they appeared, to me, to possess much interest, I have given this detailed description of them. The membranes, themselves, remain to be considered. Were they debris of acephalocysts or fibrous exudations from the bronchi? In favour of the latter supposition are to be considered, the direct bronchial irritation, which may reasonably be supposed likely to have produced the exudative tendency; the plugs which the patient expectorated being held together by fibrillated material, which points to a like tendency; the membranes being in cylindrical, not spindle shaped rolls, like portions of ordinary hydatid cysts; and lastly, the apparent good effects of the mercurial treatment, as might have been expected in a case of exudation. No traces of echinococci were found.

Moreover, hydatids in the lungs are of extremely rare occurrence, and there were no symptoms to indicate the liver as the seat of any which might have gained exit by the lungs. On the other hand, some of the membranes were of a size to preclude the idea of their having been formed in the air passages, unless in the trachea, or in a greatly dilated bronchus. But the minute structure of the membranes, especially the fineness and evenness of their lamination, appeared, to me, decisive as to their acephalocyst origin. Under the higher powers of the microscope they presented also a peculiar granular structure, which Mr. Queckett, who was kind enough to examine them, believes to be peculiar to the hydatid cyst. Dr. Bristowe, who has given considerable attention to the subject, also believes the membranes to be those of hydatids. It would be useless to speculate upon the singular coincidence between the accident to the patient and the occurrence of the parasites.

Dr. Bristowe for Dr. Leared, 21*st of April*, 1857.

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18. *Tubercular Gland pressing upon the Trachea at the Bifurcation of the Bronchi.*

The specimen was from a child, æt. twelve months, who was under observation four months.

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The prominent features of the case throughout were as follows:—Respiration quick, with expiratory effort, accompanied by a laryngeal noise, which, ever and anon, became a ringing cough. Respiration more quiet during sleep, but the prolonged expiration was striking as when awake. Percussion universally dull, except at the right apex anteriorly (four months before death). He cut his first and only tooth six weeks before death. At the same time diarrhœa supervened, and a week before death, paralysis of the right arm, with dilatation of the right pupil.

Head not examined. The middle lobe of the right lung was hepatized, every other lobe was emphysematous; lungs universally studded with tubercle, more plainly felt in the upper lobes on account of the emphysema, which was in them most marked. Two small cavities, containing pus, in the left, upper, and middle lobes. Lungs, liver, and kidneys very pale. A few of the mesenteric glands, affected with tubercle. Larynx healthy; the bronchial gland at the bifurcation of trachea as large as a hen's egg. Dr. W. Ogle, 21*st of April*, 1857.

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19. *Enlarged Thymus and Atelektasis Pulmonum in an Infant, which survived its birth four hours.*

This child was born about the seventh month, after a labour of four hours. It cried lustily at first, but soon afterwards the breathing became impeded, as though the nostrils were plugged with mucus; and when this was removed by insufflation, the respiration still continued imperfect, the nostrils remaining impervious, or nearly so, though the child cried stronger when slapped or rubbed briskly. Auscultation shewed the breathing to be bronchial, with no vesicular murmur; except under the influence of some strong stimulant the breathing ceased, and each time that it was renewed it was weaker than before, till it finally ceased, four hours after birth, the heart continuing to beat some minutes longer. During the intervals of the breathing the belly became tympanitic, subsiding again when the cry was re-established. The chest seemed pretty well expanded. The head and face were as blue as in cyanosis, while the rest of the body was almost of its ordinary colour, and this difference continued after death.

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Post-mortem nine hours after death.—Blood black and fluid. Thymus of a flattened spheroidal form, two inches in diameter by one in thickness. Heart and great vessels normal; lungs very dark, like liver, and noncrepitant; inflation of one with the blow-pipe failed to distend it, though it produced emphysematous effusion under the pleura, and neither before nor after inflation would the lungs float in water, thus shewing that an infant may live four hours and yet its lungs remain unexpanded sufficiently to sink in water.

Dr. Ogier Ward, *5th of May*, 1857.

III.—DISEASES, ETC., OF THE ORGANS OF CIRCULATION.

1. *Bony Growth on the Heart.*

This was an old preparation from Guy's museum, presented to the Society in order to gather any suggestions as to its nature. It was bought at the collection of the late Joshua Brookes, and described in his catalogue as a remarkable case of *osteo-chondromatous* tumour of the heart. The heart was an adult, and a healthy one: it had growing upon its anterior and right side a large tumour, about the size of the closed fist, being four inches and a half long and three inches broad. This had no communication with any of the cavities within, nor with the coronary blood-vessels. It was composed of a membraneous cyst, having within it a number of bony rods or spicula running through it in all directions; these were attached to the wall and to one another by fibrous tissue, and thus there were only two elements present, fibre and bone. The latter consisted of true osseous tissue, the characteristics of bone being well marked. The latter fact precludes the probability of the tumour ever having been an aneurism or the result of a mere inflammatory change; but makes it more likely that it was the skeleton of some adventitious growth which had also affected other parts of the body; or, perhaps, with more probability, that it was a congenital tumour—that it was, in fact, the remains of an included ovum

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which had become attached to the heart. Such malformations are occasionally met with, as in the remarkable case of the boy recorded in the "Medico-Chirurgical Transactions," where the remains of a fœtus were found connected with his stomach, and although we know of no instance in the human subject where a similar tumour has been attached to the heart, yet the fact has been observed in the lower animals.

Dr. Wilks, *4th of November*, 1856.

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2. *Wound of the Internal Jugular Vein, produced by a Fall upon Broken China.*

J. J., æt. 9, was admitted into Guy's Hospital, on the 1st of November, 1856, under Mr. Birkett.

Fig. 6.

Represents the external appearance of the wound.

About one hour previous to admission she was running down stairs with a chamber utensil in her hands, when she stumbled and fell upon the broken china. A scalp-wound over the right forehead was the result, and a wound over the right side of the neck, from which severe bleeding followed. No other means than the application of a piece of plaster were employed, and the

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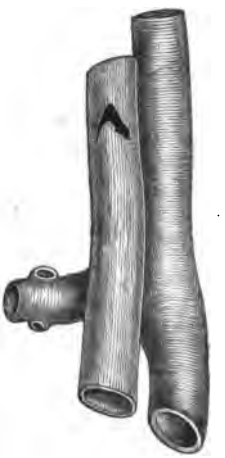
child was brought to Guy's Hospital. When admitted, she was pulseless, and in a dying condition. A wound over the right forehead existed, and a peculiar indentation of the bone, evidently produced by a sharp edge, but no fracture.

The wound in the neck was upon the right side, about one inch in length, and about one inch to the outer side of the thyroid cartilage; the edges were cleanly cut, no bleeding existed, and in less than five minutes the child ceased to breath.

On making a *post-mortem* examination, the source of the hæmorrhage was detected; the sharp edge of the broken china had perforated the skin and deep fascia, divided some few fibres of the sterno-cleido-mastoid muscle, and entered the internal jugular vein, producing a clear oblique incision in its outer wall,

FIG. 7.



The carotid artery and jugular vein, with the V-shaped incision in the latter.

about a quarter of an inch long, giving an observer the impression that the wound had been produced by a stab from a sharp instrument.

The mode of production of such an injury as the above forms the principal point of interest in the case.

Mr. THOMAS BRYANT, *4th of November*, 1856.

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3. *Cured Aneurism of the Heart.*

J. J., æt. 52, was a patient of Dr. Wilks, in Guy's Hospital, in October, 1856, for phthisis. He was a chairmaker by trade, and very intemperate; was old looking, and grey-haired. He stated that he had been ailing a year and a half, with pulmonary symptoms, but otherwise had always had good health. Nothing remarkable was observed about the position, action, or sounds of the heart. After death the lungs were found to be extensively disorganised, and the ileum was in a state of tubercular ulceration. Upon attempting to remove the heart, it was found firmly adherent by the apex, to the diaphragm, and also the lower part of its anterior surface to the pericardial sac. When taken out, a hard bony tumour was observed attached to its lower end (Plate II. Fig. 1 *a*.); this was about the size and shape of a pigeon's egg, the long diameter being placed laterally; when struck with the handle of the scalpel, it was at once found to be hollow, or not of bony consistence throughout. After the false membranes had been removed, it was seen to grow immediately from the tissues of the heart, the pericardium as well as the muscular structure of the ventricles, both in front and behind, being inextricably connected with it. Upon making a longitudinal section, it was found to consist of a perfect bony cyst, the walls being thin, but remarkably dense and hard; it contained, however, no true osseous tissue (Fig. 2.); the interior was filled with a soft homogeneous semi-transparent material, which could be separated, with tolerable facility, into distinct layers; at one spot the contents were of a pink colour, caused by the presence of hæmatine, from blood which had transuded from the ventricle. Upon removing some of this fibrinous material from the bottom of the cyst, an opening was seen passing directly into the heart (Fig. 2 *b*.). This opening was the same shape as the aneurism, and its axes had the same direction, being of an oblong form, and one quarter of an inch long, and one eighth of an inch broad; its edges were perfectly smooth, and continuous with the endocardium of the ventricle above, and with the lining of the sac below. Upon looking into the left ventricle, the serous membrane just around the opening was seen to be much thickened, and some of the muscular trabeculæ were converted into dense

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fibrous cords; this alteration of tissue was confined to the neighbourhood of the apex, the endocardium in all other parts of the cavity being quite healthy. It was thus clear that at one time a free communication had existed between the left ventricle and the aneurism, by means of this narrow opening. The right ventricle was healthy, as were the valves and the heart generally; no signs of inflammation being present except those in the immediate vicinity of the disease.

It is to be regretted that no positive history was obtained with respect to any pleuritic attacks, or injury to the chest; but judging from similar cases, in all probability no such cause existed, at least, of the former kind, for the formation of the aneurism. The so-called acute aneurisms, the pouches which are formed in the walls of the heart from inflammation and softening of the muscular tissue, in connection with a rheumatic endocarditis are not known to precede the true aneurisms, for the latter cannot, as a rule, be traced to any definite time for their occurrence, while the former are far the most fatal soon after their formation. Again, the recent pouches are met with in the neighbourhood of the valves, whereas this was at the apex. The fact of the pericardial adhesions being present is no proof of any previous inflammatory condition of the heart, since these, no doubt, were altogether secondary, and caused by the tumour. The remarkable points about the present case are the small opening leading to the sac, and the fact of complete cure; although the latter, no doubt, was due to the former. It is clear, however, that here was the case of a man who had an aneurism of the heart, than which we can hardly conceive a disease more mortal, and yet a cure having taken place, died a considerable time afterwards of an independent disease.

Dr. Wilks, *4th of November*, 1856.

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4. *Extensive Valvular Disease in a Child, dating from a Catarrhal Attack, or Rheumatism, without Articular Manifestations.*

This case had rather a pathological than a morbid anatomical interest. During life the amount of endocardial mischief was obscure on account of pericardial rubbing, but mitral regurgitant

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DESCRIPTION OF PLATE II.

The figures illustrate Dr. Wilks's case of Cured Aneurism of the Heart, p. 103.

Fig. 1. Represents the heart, reduced one third in size. The tumour, *a*, is seen attached to its apex, and a probe is seen passed through the communication between the cavity of the tumour and that of the left ventricle.

Fig. 2. The tumour, of the natural size, cut open, and seen from below.

b. Opening into the ventricle.

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Fig 1

Fig 2.

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disease, if not double mitral, was diagnosed sometime previous to death, and the morbid anatomy shewed, after death, that the conditions necessary for the production of all these sounds existed. All the valves were diseased, on the right as well as the left side; the valves of the pulmonary artery the least, the mitral valve the most. This last was, by the agglutination of the two cusps to each other, converted into a narrow ring, through which the extremity of the finger could barely be passed, which must have given rise to great obstruction, whilst the contraction of the smaller blade of the valve, and its adhesion to the wall of the ventricle allowed tolerable regurgitation. But the chief interest of the case lay in its history—in the fact that these extensive results of inflammation were unpreceded by any recognizable acute attack. The child had never had rheumatic fever, or even rheumatic pains of any decided character, but though diminutive and pallid, had always enjoyed good health. Last Christmas she caught a cold, which left a little cough, but did not confine her to the house, or interrupt her attendance at school a single day. From this time she noticed palpitation, and a slight pain in her left side; this, with a short dry cough, gradually increased till May, when she applied for relief. The signs of endocardial and pericardial mischief, and the usual concomitant symptoms were now present. The case terminated fatally in the last week of October, nearly six months after admission, the principal features of its course being extreme dyspnœa, universal dropsy, rupture of the cutis in the legs and back, continual draining of serum, great emaciation, and finally sinking.

This history seems to me to imply, as the essential pathology of the case, one of two alternatives, either of which is interesting —either that the apparent cold at Christmas was really a rheumatic attack, in which there were no articular manifestations, but in which the rheumatic inflammation fell entirely on the heart, (and I believe the existence of such cases is disputed, although the occurrence of severe rheumatic heart-disease, with faint, though decided, articular symptoms, renders such an occurrence highly probable,) or else the poison of catarrh is capable of producing inflammation of the structures of the heart, as well as that of rheumatism. Seeing the many points of analogy between

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febrile catarrh and rheumatic fever, (in causation, pathology, symptoms, &c), this last supposition appears to be very probable. These views, if they are correct, would tend to explain the so-called cases of "spontaneous" and "latent" heart-disease in children, and to diminish, in respect to the heart, what the present advances of pathology are constantly decreasing, idiopathic inflammations.

DR. SALTER, *4th of November*, 1856.

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5. Sacculated Aneurism of the Arch of the Aorta.

The patient, æt. 54, a robust man, with large chest, had suffered for nine months from cough of a paroxysmal character, and accompanied with expectoration of frothy mucus matter. When first seen, in February 1856, he complained of considerable dyspnœa, and a sensation of tightness in the chest, not occurring so much in fits like the asthmatic seizure, but constant, and aggravated at times till it became extreme. This symptom steadily increased till his death. He had pain in the right side of the sternum, and through the chest to the right side of the spine. At one time he had slight dysphagia. The peculiar alterations in the key of the voice, often present in cases of aneurism were not heard in this case. He spoke generally in a rough, rather hoarse tone.

The physical signs were:—Deficient respiration over the whole right lung, with clear percussion note, except at the apex, and a space encroaching on the sternum opposite the third right rib articulation, where there was very decided dulness.

There was slight pulsation in this spot, which decreased gradually on approaching the heart, forming a centre of pulsation distinct from that in the cardiac region. There was no murmur of any kind, either over the seat of dulness, nor in any part of the chest, nor above the clavicles. The left radial pulse was sensibly less full than the right. He now removed to the country, and returned, after some weeks, worse, the dyspnœa and his other symptoms having increased to a painful extent. He was at this time under the care of Mr. Evan Jones. I had for some time past made up my mind that the disease was aneurism of

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the aorta, and the diagnosis was confirmed as the case progressed. His sufferings, at the last, were extreme; his distress from dyspnœa being very painful to witness. His last few days were passed in a chair and he was constantly fanned.

The *post-mortem*, made twenty hours after death, revealed a large bisacculated aneurism of the first portion of the arch of the aorta, lying immediately in contact with the sternum, and occupying the space indicated by the dulness on percussion. A second sac opened from the back of the arch and pressed on the right bronchial tube, slightly on the trachea, right pulmonary artery, and œsophagus. Both sacs were deeply lined by laminated coagula. The right lung was much congested in its upper lobe, being scarcely pervious. Both lungs exhibited the appearances of bronchitis throughout their whole structure.

Dr. Pollock, *4th of November*, 1856.

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6. *Malformation of the Heart; no Cyanosis.*

This case is interesting as an instance of that kind of malformation of the heart, in which the aorta arises from the two ventricles, the pulmonary artery being quite impervious at its junction with the ventricle. The history was briefly as follows:—

A woman, the mother of five children, all of whom had been tolerably healthy, gave birth, in November, 1856, to an apparently healthy male child. The labour was natural, but the cord was twisted round the child's neck three times. After being liberated from the mother the child cried once, not very loudly, and never cried afterwards for a fortnight. The child soon lost its healthy appearance, and wasted rapidly; was so feeble as hardly to be able to take the breast, and seemed almost choked "when the draught came." Four days after birth jaundice set in, lasting four days.

On the 14th of January, 1857, (ten weeks after birth,) I saw the infant for the first time. The skin was extremely white and transparent, and round the eyes of a light red colour; no fat on the limbs or body, face expressionless. The child breathed quickly, but not as if suffering distress; it slept little, and occasionally cried a good deal, at which time the face and body

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was said to become darkish in colour, but never decidedly blue. The heart's action was visible over a large surface, and its dulness co-extensive. The circumference of the chest was only ·31 met. (twelve inches and one eighth) and the increase of measurement in inspiration only amounted to ·002 met. All over the front of the chest was heard a loud systolic murmur; at the xiphoid cartilage, where the impulse of the heart was most evident, a feeble second sound was heard; at the base of the heart, the murmur replacing (as it is supposed) the first sound, was very loud and had a rasping character, and was followed by a slight second sound. The murmur was heard also at the back of the chest. The lower ribs and cartilages were drawn in during inspiration; a slight healthy respiratory murmur was heard in front, but little behind. The child coughed now and then, but feebly; the skin was loose and hung in folds, its temperature rather low; pulse, one hundred and sixty; respiration, thirty in the minute.

Under treatment, slight improvement was manifested; but on the 14th of February the eyelids appeared anasarcous, and the child was then much worse in every respect. The auscultation of the chest revealed the same state of things as before; the lips were bluish, the breathing slow and irregular; the child took the breast with difficulty, and required to be constantly close to the fire in order to be kept warm. On the 14th of February a kind of convulsive attack was noticed, during which the body became blue, and on the 26th death took place.

The heart was removed from the body the following day. It was situated rather more to the right than usual; measured transversely ·05, by ·025 met. vertically. The pericardium contained about half an ounce of serosity. The excessive transverse diameter was due to the enlargement and thickening of the right ventricle, and the greater part of the transverse diameter passed through this cavity. The circumference of the right ventricle, at the base, was ·07, of the left at the same situation, ·05 met.; the vertical diameter of the right ventricle was ·03, of the left, ·033 met. The right auricle was large, and contained fluid blood, with a small fibrinous clot. The left auricle was rather large and contained semi-coagulated dark blood. The ventricles were both empty.

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The foramen ovale was open, measuring ·005 met.; the corresponding opening in the left auricle was situated ·008 met. higher up than the other, the passage running obliquely upwards from the right auricle.

The thickness of the ventricular walls was as follows:— At its base the right ventricle was ·01 thick, elsewhere ·006-·008 met.; the walls of the left ventricle, at the thickest part, measured ·01 met.

The tricuspid orifice measured ·04 met.; the mitral, as nearly as possible the same.

The ventricular septum was deficient at its upper part, allowing the little finger to be passed from one ventricle to the other. Both ventricles thus opened into a recess from which the aorta was given off. The aorta itself, was large, the semilunar valves, three in number, were very large and loose; when distended they nearly reached as far as the upper border of the ventricular septum. The two ventricles consequently communicated freely with the aorta.

No pulmonary orifice communicating with the right ventricle could be detected. On looking for the pulmonary artery, however, outside the ventricle, a small vessel was observed, which had been cut across a quarter of an inch from its insertion into the base of the right ventricle; this vessel measured about one and a half millimetres in diameter; a probe passed into it towards the ventricle, was stopped abruptly at its junction with the cavity, the orifice being quite obliterated. This vessel bifurcated at rather less than an inch from the ventricle, one branch being rather smaller than the other. The heart was unfortunately not examined at the time of its removal from the body, so that the further course of these two canals was not followed. From what has been observed, however, in analogous cases, the probability is that one of these vessels was the ductus arteriosus, and that it would have been found if examined in situ to have joined the aorta.

The lungs exhibited in their lower lobes, and in portions of the upper, the condition known as atelektasis; some of these portions were very firm, and the lung at these situations resisted artificial inflation. Nearly the whole of the left lung was in

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this condition, having never been expanded by respiration. The upper right lobe was emphysematous, increased in bulk, and extending over to the opposite side of the thorax. The other organ presented nothing remarkable.

The malformation here observed is that which has been most frequently described. It is not uncommon to find the aorta coming off from both ventricles; but it is less usual to find the pulmonary artery completely impervious at its origin as was the case in this instance. In the cases recorded by Farre, Peacock, and others, obliteration of the pulmonary orifice has been found to be conjoined with an open condition of the ductus arteriorus, the blood finding its way into the lungs through the aorta, and also with an open foramen ovale. The case here given is imperfect, inasmuch as the existence of the communication between the aorta and the pulmonary artery was not verified.

The connection between the malformation here described, and the atelektasis, is of course sufficiently evident. The lungs never received the proper quantity of blood, they were never duly expanded, and the thorax was remarkably small. During life, the physical examination of the chest showed the presence of the latter condition; the loud systolic murmur indicated the presence of something unusual, in reference to the state of the cardiac orifices, but nothing more definite in the way of diagnosis was arrived at. It is usual in such cases to find the cyanotic symptoms more marked than in the present instance; the skin was here remarkably pallid, its temperature extremely low, and the process of nutrition much interfered with. It shows, in common with others of a similar nature, that the admixture of arterial and venous blood does not necessarily produce a cyanotic tint in the skin, a fact which, indicated by Morgagni, was more clearly pointed out by Kreysig and Louis; the latter of which observers demonstrated that the occurrence of the cyanotic tinge resulted from impeded flow of venous blood back to the heart, or from thence to the lungs.*

Dr. Graily Hewitt, *17th of March*, 1857.

* *See* Hasse, p. 178, of "Syd. Soc. Trans."

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7. *Hypertrophy of the Heart, Pericarditis, &c., in a Child.*

The patient, H., a little girl, æt. 7, was taken ill on the 17th of August, 1856. For three days the symptoms consisted of general feverishness, heat of skin, and general feeling of soreness. An eruption now made its appearance on the back and belly, having most of the character of erythema, the pains in the limbs and fever still continuing. This eruption continued for three days, disappearing after the manner of patches of purpura. On the 21st of August, one of the wrists was swollen and painful; copious perspiration was observed, and all the symptoms of acute articular rheumatism set in.

On the 25th of August.—A systolic mitral murmur was heard at the apex of the heart; the other wrist was now swollen and very painful.

On the 3rd of September.—The articular pain had somewhat abated, but there was tenderness at the epigastrium and slight mitral murmur; the patient was able to sleep a little; skin excessively pale and anæmic; perspirations very profuse.

On the 13th of September.—Great emaciation; unable to sleep; respiration difficult; heart's action diffused; no dulness at second left costal interspace; all the heart's sounds preternaturally loud, the first sound more altered than the second, and mostly so at the apex.

On the 18th of September.—Just a month after the commencement of the illness, a loud whistling murmur was heard at the apex with the first sound, and the second sound at the same spot was altered in character. The emaciation had increased, as also the dyspnœa and inability to sleep; respirations seventy-six in the minute; face very pale; no appetite. The following night dyspnœa extreme.

On the 19th of September.—The feet began to swell, the dyspnœa appearing at the same time to be a little relieved. Three days afterwards, improvement marked, the patient being able to sleep. Heart sounds as before.

On the 24th of September.—Rheumatic pains again experienced in one or two of the joints. For the next month, the patient's condition was a variable one, now better, now worse.

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The sounds of the heart remained much as before. At the end of that time the emaciation had progressed considerably.

On the 18th of October.—Face and legs anasarcous; sickness; pain at epigastrium, and dyspnœa were complained of. The following day the legs became still more anasarcous and very cold.

On the 20th of October.—Face swollen; great thirst, and pain across the abdomen; heart's action felt over a large surface; no undue dulness at second left interspace, both sounds blended together at apex. Pulse exceedingly rapid; respiratory murmur heard all over both the lungs, and over the heart also; at the extreme base of both lungs, however, rather weak, and at these situations there was slight dulness on percussion; patient a little drowsy.

On the 21st of October.—Pain in abdomen continues; respirations forty; abdomen measures twenty-three inches round most prominent part. A distinctly marked venous pulse in the external jugular vein on right side. Liver dulness reaches too low; urine very scanty, loaded with lithates, contains no albumen.

On the 29th of October.—Anasarca of lower extremities very considerable. Dyspnœa not so great as before, but the patient cannot lie down.

On the 1st of November.—A frequent short cough is a source of great trouble to the patient; she is drowsy, but eats a little food; anasarca extended to the loins; venous jugular pulse very marked; no fluid in pleural cavities; abdomen more protuberant; fluctuation there tolerably evident: loud whistling systolic murmur at heart's apex; respiratory murmur at apices exaggerated in intensity; great pallor of skin; feet cold.

On the 5th of November.—Symptoms as before. Urine contains a little albumen.

On the 9th of November.—Labia majora enormously swollen; as also lower extremities and trunk.

On the 17th of November.—Death took place, just three months after the commencement of the rheumatic affection.

Autopsy.—Fourteen hours after death.—Body greatly swollen; skin very pallid; circumference of leg just above ankle, eight

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inches and six-eighths. Abdomen containing about a pint of serous looking fluid. Liver of a dark brown colour, measures transversely nine inches, vertically five inches, thickness six inches; vessels much gorged with blood; spleen normal; left kidney, four inches and a quarter vertically, by two inches and a half transversely; right kidney, three inches and three-quarters, by two inches, both congested, but otherwise healthy; bladder empty; stomach and intestines healthy. Right lung adherent everywhere, except at apex, where a small quantity of fluid is collected; lung very large, twice the size of the left when both are laid on the table and compared together; only crepitant at one or two points; elsewhere substance very firm; section exactly resembling that of the liver in colour and consistence, sinks in water. Left lung, almost everywhere crepitant, not adherent; portions of lower lobe indurated and resembling the other lung. Left pleura contains several ounces of fluid.

Pericardium contains a small quantity of fluid only. The two layers are granular on the surface, covered by a coat of yellowish-white-coloured tenacious lymph, varying in thickness, most abundant over that part of the heart corresponding to the auricles. Thick bands pass across, uniting the visceral and parietal layers at the bar of the heart, which bands are, however, easily broken down.

Heart weighs seven ounces and a half. Right auricle contains white semi-transparent coagula, as also the right ventricle; in the latter cavity it is very tough and firm, occupying all the depressions and irregularities most completely. Left ventricle contains semi-coagulated blood, like black currant jelly. The mitral valve presents delicate warty vegetations on its auricular aspect; allows of regurgitation. Tricuspid valve delicate and thin; action imperfect. Aortic valves not quite perfect in action, healthy. Circumference of orifices:—Pulmonary, two inches; aortic, one inch and fourteen-twentieths of an inch; tricuspid, three inches and fourteen-twentieths of an inch; mitral, three inches and fourteen-twentieths of an inch. Thickness of walls of heart:—Left ventricle (greatest), ten-twentieths of an inch; right ventricle, six-twentieths of an inch; left auricle, five-twentieths of an inch; right auricle, three-twentieths of an inch.

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Remarks.—The disease was rapidly fatal, the disturbance of the circulation becoming every day greater as the heart became more affected. The heart, especially its right side, was greatly hypertrophied. The absence of any great degree of patency of the tricuspid orifice viewed in connection with the occurrence of jugular venous pulse during life, is worthy of remark. The case may be regarded as complete, inasmuch as it was under observation from the commencement to the termination. It may not be uninteresting to mention, that a sister of the deceased died at about the same age, and after a shorter illness, of heart affection following scarlet fever.

Dr. Graily Hewitt, 18*th of November*, 1856.

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8. *Fibrinous Deposits in the Heart, with Fibroid Degeneration.*

A boiler-maker, æt. 31, was admitted into St. Thomas's Hospital, under the care of Dr. Bennett, on the 7th of October, 1856. He was of a pale and somewhat sallow aspect, but not much emaciated. He stated that, for two years he had been the subject of cough, with some expectoration; and that, a fortnight ago, he had had slight hæmoptysis, which lasted for two days. He complained, on admission, of shortness of breath, pain across the chest, and cough, and of considerable debility. His pulse was feeble, ninety-four; urine, specific gravity 1·018, and not albuminous. There was dulness under both clavicles, more especially under the right, and the respiratory murmur was very deficient. Lower down, coarse mucous crepitation was heard. There was some œdema of the feet and legs. Under a tonic treatment he improved somewhat, for awhile, but soon relapsed, and became weaker, the œdema of the lower extremities increasing, and he complained more of the tightness of chest, of cough, and of dyspnœa. The pulse and the heart's action were feeble, but no distinct cardiac bruit could be detected. On the 2nd of November, whilst in the act of reaching for something at a little distance, he fell back and expired.

Post-mortem examination.—Each plural cavity contained nearly a quart of serum. The right lung was bound down by numerous old firm adhesions. On cutting through the root, a large quan-

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tity of frothy mucus exuded. The bronchial tubes were greatly congested. The apex was also congested, containing much frothy fluid, and was but imperfectly crepitant: it contained several masses of tubercle. The left lung was similarly adherent to the parietal pleura. In the apex were several tubercular cavities, and the whole upper lobe was much congested, and, like the right, very imperfectly crepitant. The heart weighed fourteen ounces, and was universally adherent to the pericardium. The valves were healthy. Within the substance of the heart were numerous whitish masses, gradually fading into the muscular structures. Some of these were situated near the pericardial, others near the endocardial surface; the latter were, for the most part, situated in the septum ventriculorum. On closer examination, these masses were, clearly, neither tubercular nor cancerous, but fibrinous, and infiltrated the muscular tissue. Muscular tissue was seen permeating the fibroid deposit; but the striæ were, in many places, very indistinct, and, in others, had quite disappeared. The microscopical characters of the deposit corresponded so exactly with those detailed in the reports given to the Society, in connection with the first case described by Dr. Bennett, in the third volume of the "Transactions," pp. 273, &c., and that of Dr. Bence Jones, in the seventh volume, p. 167, that it is unnecessary to give them again.

With the exception of the liver, which was mottled, the other organs were healthy.

Dr. Risdon Bennett, *2nd of December*, 1856.

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9. *Great Hypertrophy of the Heart, and Disease of the Aortic Valves, with Absence of Impulse and Heart-sounds.*

H. W., æt. 47, mariner, first seen on the 7th of April, 1856; had then suffered from dyspnœa and palpitation for some weeks. He had symptoms of cardiac disease, and the legs were œdematous. There was very extensive dulness in the cardiac region, but no impulse, and the heart's sounds were not perceptible. Pulse one hundred and twenty, moderately full and jerking. He was seen by several persons between this date and the day of his death, on the 11th of April, and on no occasion could

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the impulse of the heart be felt, or its sounds heard, except occasionally, and then most faintly. The dyspnœa and palpitation were slightly relieved; but, on the morning of the 11th of April, being slightly excited, he died suddenly.

The absence of impulse and sounds of the heart were not explained, either by the heart being unusually overlapped by the lung, or by pericardial effusion. The pericardium contained only a few ounces of fluid, and it was in contact with the parietes of the chest to an extent much greater than ordinary. The heart was covered by a thin reticulated layer of old lymph; it weighed twenty-eight ounces. The walls of the left ventricle were firm and healthy-looking, and were three-quarters of an inch thick. The aortic valves were quite incompetent; the right and posterior ones appeared to have been united, and a thick, cartilage-like rim extended along the whole of the free edge of the compound valve. The remaining portions of these, and of the third valve, were considerably thickened. The aortic sinuses were thickened and studded with earthy and atheromatous matter. The surface of the septum, for an inch below the valves, presented patches of old membrane, and a similar deposit existed on the anterior curtain of the mitral valve, the chordæ tendiniæ of which were somewhat thickened. On the whole, the mitral valve appeared tolerably healthy. The cavity of the right ventricle was much dilated, and filled with soft fibrinous coagulum; its walls were about one quarter of an inch thick, and appeared healthy. Nevertheless, the transverse markings of the muscular tissue were generally indistinct, and, occasionally, the fibres were granular, and some of them presented longitudinal streaks of oil-globules.

Dr. Barker, 16*th of December*, 1856.

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10. *Fibrinous Deposit in Masses within the Substance of the Heart's Walls. Peculiarities in the Pulse.*

The specimen consisted of a heart, having a large amount of fat upon its outer surface and the walls of both ventricles, but especially of the left one, thickened, and presenting in the substance of the septum of the ventricles, and in the anterior wall

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of the left ventricle, masses of fibrinous deposit. These deposits, which were confined to the base or upper part of the heart, were of various sizes, and of a yellowish-white hue, and firm consistency; and on the right side of the upper portion of the septum, they were so prominent as to bulge into the cavity of the right ventricle. The lining membrane of the heart, seen to cover the deposit on both sides of the septum, was thickened and very opaque. The various valves and orifices of the heart were quite natural, and there was only a slight amount of atheroma at the root of the aorta. The pericardial bag contained much turbid fluid and flakes of soft fibrine. The lungs were highly congested at their lower and posterior parts, and, in places, were emphysematous.

The kidneys, liver, and spleen were very congested; and the blood, generally, throughout the body, was more than unusually fluid, less coagulum than ordinary existing.

History.—The specimen was removed from the body of H. N., æt. 30., an emaciated and anæmic-looking man, who was admitted into St. George's Hospital with cough, and slight uneasiness at the front of the chest. The heart's action was feeble, its sounds distant and muffled, and the pulse, though regular, only forty-eight per minute. The tongue was clean, but the bowels confined; the skin was cool. The patient stated that he had had rheumatic fever seven years before his admission, but excepting that illness, had had good general health until two months before admission, when, following an attack of diarrhœa, he had a series of epileptic attacks attended by foaming and much struggling; and, on several occasions, vomited blood. After treatment in the Hospital, for about two weeks, by means of tonics, and sedatives, and port wine, &c., he was rather suddenly affected by fainting fits, and attacks of giddiness, which lasted all day long; the cough became worse, and there was great uneasiness of the chest, and restless, disturbed nights. Pains in the loins came on, and tympanitis, and the pulse was remarked on several occasions as being as low as thirty-six per minute; it was never counted higher than fifty. The urine was generally turbid, but free from albumen. He gradually sank, and died about six weeks after admission.

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Remarks.—The chief points of interest for which the case is brought forward is, the state of the pulse, as possibly respective of the deposit in the walls of the heart's ventricles; but, as the next case presents a similar point of interest, it will be more considered in "Remarks" at the end of that case.

Dr John Ogle, *16th of December*, 1856.

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11. *Fibrinous Deposit Infiltrated, and in Masses within the Substance of the Walls of the Heart. Tendency to the Formation of an Aneurismal Pouch. Peculiarities in the Pulse.*

The specimen showed deposits of fibrine, occupying the walls of both ventricles, and chiefly their septum, restricted almost entirely, as in the previous case, to the upper part or base of the heart. The deposit on the right side of the heart was in the form of distinct masses, appearing immediately beneath the endocardium, which was thickened; but, as a rule, the deposit was diffused, or, as it were, infiltrated throughout the muscular tissue, rendering it hard and tough, and consolidated. In one place, at the base of the septum of the ventricles, where there was much hardening, there was, at the same time, a thinning and depression of about the size of a shilling seen on the left side of the septum, shewing, evidently, a tendency to a bulging from the left into the right ventricle, and the formation of an aneurismal pouch. The walls of the left ventricle were rather hypertrophied, and the aortic valve flaps, as well as the walls of the aorta, at its root, were very thickened and rigid. The lungs were very congested, and there was found a large quantity of serous fluid in the pleural cavities on both sides.

History.—The preparation was removed from the body of a woman æt. 35, who had suffered for many years from evident symptoms of some disease of the heart, but there had been freedom from general dropsy. The cough and dyspnœa, &c., existed, but the chief symptom worthy of notice was that of her pulse, which, at all times, when under observation, faultered at every third beat, being then so very feeble, as to be almost always, and often quite imperceptible. How long this had been

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so could not be ascertained. It was not found that she had ever had rheumatic fever.

Remarks.—As in the previous case, the most salient point connected with the present one is the peculiarity of the pulse. In the present case, the regular and uniform irregularity in its rhythm was particularly observable, whilst, in the former one, the reduced number of beats per minute attracted attention. It is deserving of notice, that in several similar cases, the presence of fibrinous deposit in the substance of the heart, and what has been called fibroid degeneration of the muscle (a condition most probably often traceable to infiltration of fibrine), have been accompanied and marked by some interference with the rhythm, or the rate of beating of the heart. On this point I may call to mind a case in which large quantities of firm fibrinous deposit existed in the septum of the ventricles brought before the Society by Dr. Bence Jones, on the 20th of November, 1856. The patient was æt. 33. In this case, the pulse, on the patient's admission into St. George's Hospital, was thirty-six per minute; it afterwards sank as low as twenty-eight per minute, and was the subject of close attention for some time.

It is worthy of notice here, that both in the case of Dr. Bence Jones, just alluded to, and in the two cases just submitted to the notice of the Society, the heart's walls were occupied by the foreign deposit, mainly towards the base of the heart.

On reviewing the various cases of similar deposit in the heart's walls, brought from time to time before the Pathological Society, and detailed in its "Transactions," it will be seen that some point of interest as regards the pulse and the rhythm, or rate of beats of the heart, has been placed on record in the histories of the majority of them.

In the years 1851-52, three cases were submitted to the Society —one by Dr. Risdon Bennett, related at p. 273 of the "Transactions" for that year—one by Dr. J. Bird, related at p. 276, and one by myself, related at p. 281. In the years 1854-55, a specimen was presented by Dr. Bristowe, related at p. 148 of that year's "Transactions," which, with Dr. Bence Jones's, mentioned above, makes the fifth case to which allusion shall be made.

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As regards Dr. B. Jones's, nothing more than that which was above specified, need be said. With reference to the second case, Dr. R. Bennett's, that of a man, æt. 50, it is stated in the details of the case, that the "pulse was very small and feeble; the systole of the heart * * *, followed by a distinct natural second sound, to which succeeded a remarkably prolonged interval of rest; the rhythm was frequently irregular. With regard to the third, Dr. Bird's case, that of a man, æt. 50, it is stated that the pulse at one time "was one hundred and ten, irritable and jerking." Later on, it is said that the pulse was "ninety-eight, and feeble, but without intermission;" and, later still, that the pulse was "intermittent, and only numbered fifty-five." Subsequently it rose again. In the fourth case, that by myself, the patient, a woman, æt. 22, was admitted into St. George's Hospital, so collapsed, that she died on the day after admission. She was suffering so greatly, that all physical examination of the lungs was precluded; but, on turning to private notes of the case, it is stated (by an error the fact was not mentioned in the "Transactions,") that "no action or sound of the heart was perceived before death." It is impossible, then, to say, as regards the pulse in this case, how far it was affected by the peculiar state of the heart. In the fifth case, that of a woman, æt. 39, related by Dr. Bristowe, it is stated that the "heart's action was feeble and irregular," but nothing more. Thus, out of the seven cases, including the above-quoted five, and the two now brought forward, there are no less than five, in which coincidently with the occupation of the heart's walls by fibrinous deposit, we have some marked and peculiar alteration in the rhythm, or rate of beat of the heart, and it seems very highly probable that there is something more than a coincidence in all this; but, of course, the observation of more numerous instances is required before any certain statement upon the matter can be affirmed. Supposing this deposit in the heart's walls, and the peculiarity in the pulse and heart's action to stand in relation to each other, as cause and effect, the pathological explanation of such a connection is far from being obvious; and this, of necessity, is owing to our comparative ignorance of the natural physiological cause of the rhythmical nature of the heart's movement. To seek closely

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for such a pathological explanation, we should have to examine, on the one hand, the physiological theories which have been maintained in proof of the influence of the nervous ganglia situated within the heart upon its motion; and, on the other hand, those which would attribute such motion to some innate endowment or power of the muscular fibre itself, and would connect it with some mechanical regulation or disposition of the fibres; an examination like this, would of course, be utterly out of place here.

In several of the above cases the deposit was found to occupy the heart's structure mainly towards the *base* of the heart, and this fact becomes naturally associated in one's mind with those experiments which were performed on the frog and other animals,* in which it was demonstrated, that a very clear and sensible connection existed between the integrity of the great transverse fissure of the heart, and the movements of the ventricles. Thus, the amount of interference with the action of the heart may depend as well upon the locality which may be affected by the deposit, as upon the degree to which it occupies the heart. Possibly this interference with the heart's motion may be found to be also connected with other deposits, as the carcinomatous, or what is still more rare, scrofulous deposit within the heart's substance.

Dr. John Ogle, *16th of December*, 1856.

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12. *Destruction of the Pulmonary Valves by Disease.*

M. G., æt. 11, was under Dr. Rees's care, in Guy's Hospital, in December, 1856. Her mother stated that she was ill at birth, being born with rheumatism and heart-disease; and was with difficulty reared until the age of three years, when her health much improved, although she was always delicate. About a year before her death, she took cold, and was laid up again with rheumatism, at which time her medical attendant said she had disease of the heart. After this, she suffered much from dyspnœa, but was able to walk about, and remained tolerably well until the approach of winter, when, the chest symptoms becoming

* *Vide* Valentin's "Text Book of Physiology."

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worse, she came to the Hospital. This was six weeks before her decease. She did not appear very ill, although it was clear that a great amount of mischief existed in the heart. There was a loud systolic bruit heard over all the cardiac region, and a less diastolic bruit over the sternum, and towards the left side. There was dyspnœa, but not lividity, nor any approach to cyanosis; no hæmoptysis nor dropsy. There were no remarkable symptoms indicative of the great obstruction to the pulmonary vessel, which was found after death, which latter event took place slowly; the only fresh occurrence being the appearance of a few purpuric spots on the legs. Upon *post-mortem* examination the body were seen to be moderately well developed; the face was slightly congested, a few purpuric spots on lower extremities, no œdema of any part. The pericardium was healthy. The heart was about the size of that of an adult, and this enlargement was due principally to the increase of the right ventricle, which formed the bulk of the organ, extending, as it did, much below the left ventricle, and altogether preponderating over it. It thus presented the appearance of the heart in chronic contraction of the mitral orifice. Upon opening it, the comparative sizes of these parts were still seen; the right ventricle being enlarged, and walls hypertrophied. It was evident from the large size, prominence, and hardness of the pulmonary artery, that disease existed within it. When incised, it was found to be completely filled by a firm mass of fibrine, which extended upwards into the lungs, and downwards into the ventricle, not the smallest passage being left for the blood. This clot of fibrine was hard, of a whitish colour; presented no appearance of softening within, and was closely adherent to the walls of the vessel. It projected into the ventricle, where it was continuous with the recent coagulum, and was firmly connected with the endocardium at the orifice. Upon raising up the fibrine to seek for the valves, the latter were found to be quite destroyed, not a vestige being left of them, and in their place was the excoriated interior of the pulmonary artery everywhere covered with fibrine; this was closely continuous with the clot within. The latter proceeded into the right and left pulmonary arteries, and to the larger branches, and there stopped, the smaller vessels being free. The whole of the coats of the artery

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were thickened, and the inflammation had extended downwards a short way into the ventricle; thus the endocardium of the anterior part was ulcerated, and the muscular tissue beneath was infiltrated by lymph. The foramen ovale was open by a vavular communication, such as is not unfrequently met with, and would admit the point of the little finger. From the aortic valves there hung down large vegetations into the ventricle. The other valves were healthy. Liver was in an early stage of the nutmeg condition. The kidneys were covered with hæmorrhagic spots, from a slight effusion of blood into the Malphigian bodies. The spleen was rather large.

It would thus appear that endocarditis had occurred about the time of birth, and a certain amount of disease set up at the pulmonary orifice, and that about a year before death, owing to a fresh attack of rheumatism, a complete destruction of the valves had taken place, followed by a deposition of vegetations and coagula, which at last entirely filled the artery.

Dr. Wilks, *16th of December*, 1856.

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13. *Malformation of the Heart in a Child. Cyanosis.*

E. S., æt. 1 year and 1 month, is stated by her mother to have been born at the full period, and after a natural labour.

Father, æt. 27, and mother, æt. 33, are both in good health. They have had four children; the eldest, æt. 5, is living, but is consumptive; two others have died, one from teething, the other from inflammation of the chest.

E. S. appeared quite healthy when born, and continued healthy in appearance until seven months of age. (This statement of the mother is confirmed by the aunt). At seven months, two lower incisor teeth were cut, and the child had, to use the mother's words, "a slight convulsion, but no regular fit." This slight convulsion was explained to be a little catching of the breath, and darkness round the mouth, without any distortion of the features, or movement of the limbs. From this time (seven months of age) the child became blue, but was occasionally much more so than at other times. At eight months, a violent convulsion occurred, and, after two or three days, a second; and since that time

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she has had them almost every day, and sometimes very many in the course of a day.

When first seen by myself, at the age of twelve months, at the Hospital for Sick Children, she was in a fit. The pupils were excessively dilated; the radial pulse weak, and almost imperceptible; the skin generally of deep leaden hue; there was a murmur, loud, harsh in quality, and systolic in rhythm over the whole cardiac region. Suddenly the pupils contracted, and at the same moment the radial pulse filled, and the child made an apparently voluntary movement of the head; but the murmur and the dark colour were persistent.

When seen upon a subsequent day, no fit had occurred for twelve hours. The face was found very blue, and the mucous membrane of the mouth, and the angles of eyes almost black. The surface generally was dark and cool; the fingers were not at all clubbed in shape, but appeared larger than natural; the toes were all bulbous.

Auscultation of heart.—At the base, a loud, harsh, long, systolic murmur, obscuring both sounds. At the apex, both sounds of the heart audible, but a murmur accompanied the first. At the second right cartilage, systolic murmur audible, but less so than at base, and second sound distinct and flapping. At the second left cartilage, first sound accompanied by murmur, second sound almost inaudible. Murmur not audible posteriorly in either interscapular region.

Respiration is forced, and each expiration is attended by a grunting sound. Frequency of respiration, thirty-six in the minute.

From the time when this child first came under my observation, on the 4th of November until the 16th of November, the fits recurred very frequently, and during the 14th and 15th she coughed much, and vomited her food. On the 16th she died, exhausted by repeated convulsions.

Post-mortem examination, twenty hours after death.—Weight of body, thirteen pounds and a half. Height, twenty-eight inches. Width across shoulders, from acromium to acromium anteriorly, six and a half inches. Length of trunk from sternum to pubis, nine inches.

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Body lying on back.—Anterior upper half pale; posterior lower of pinkish blue colour. Body well nourished. Rigor mortis in lower extremities.

Thorax.—No part of left lung is visible anteriorly; lungs perfectly healthy in appearance. Pleura perfectly healthy in appearance. Pericardium perfectly healthy in appearance.

The heart presented the following anomalies:—

Right auricle receives as usual the two venæ cavæ, but the foramen ovale is open.

Right ventricle communicates as usual with the right auricle, through a large orifice, guarded by the tricuspid valve. But the right ventricle gives origin to the aorta; and in its upper portion, immediately below the aortic valves it presents a large opening, communicating with the left ventricle. The right ventricle also gives origin to the pulmonary artery, but the opening of this latter vessel is small, and anterior to that of the aorta. The whole ventricle communicates and becomes continuous with the aorta, but the orifice of the pulmonary artery is almost lost in the ventricular walls.

Left auricle receives two pulmonary veins, communicates through the foramen ovale, with the right auricle, and through the mitral orifice with the left ventricle, which communicates behind the aortic flap of the mitral valve with the right ventricle.

Notwithstanding this disposition of the vessels, the aortic flap of the mitral valve is attached, as usual, to that portion of the intra-cardiac cartilage, which supports the left and posterior aortic valves.

The auriculo-ventricular valves generally are healthy.

The aorta has three semi-lunar flaps, healthy; the pulmonary artery presents only the rudiments of two. The Eustachian valve is well developed.

The ductus arteriosus is, contrary to what usually exists in cases of this aortic origin, closed.

Measurements:—

Aorta, circumference at attachment of valves, one inch and three-eighths. Aorta, circumference in arch, one inch and three-eighths. Aorta, circumference at opening into

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right ventricle, one inch and one-eighth, Pulmonary artery, at widest part five-eighths of an inch. Communication of two ventricles, circumference, seven-eighths of an inch. Mitral orifice, at valvular attachment, circumference, one inch and seven-eighths. Tricuspid orifice, at valvular attachment, circumference, two inches and one sixteenth. Fossa ovalis, circumference in right auricle one inch and a half. Foramen ovale, circumference, six-eighths of an inch. Wall of right ventricle, thickness in thickest portion, three-eighths of an inch. Wall of left ventricle, thickness in thickest portion, one quarter of an inch. Length of right ventricle, from aortic valve attachment to apex, two inches. Length of left ventricle, from aortic valve attachment to apex, two inches. Length of left ventricle, from margin of origin to apex, one inch and three-eighths. From aortic valves to orifice of left ventricle, five eighths of an inch.

Dr. Russell Reynolds, *16th of December*, 1856.

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14. *Unusually Large Ossific Deposits within the Mitral Valve.*

Mrs. B., æt. 45, was attacked on the 2nd of June, 1856, with cough, fever, and some difficulty of breathing. Is a woman of anxious temperament, has worked hard at her domestic duties, and has always had sufficient and wholesome food. Twenty-five years since she had severe rheumatic fever, and a little more than two years since had an attack of pleurisy. A month or two before this attack she had lost an only son, which had preyed very much on her mind. She was considerably emaciated.

When first seen, she complained of cough, fever, and occasional fits of palpitation and dyspnœa. The pulse was over one hundred; respiration thirty in the minute. Has moist, crepitant rhonchus over the posterior and inferior portions of both lungs. The impulse of the heart was moderately strong, and felt over the natural space; over the apex was a loud sawing diastolic murmur. Salines and stimulants were administered, by which she was greatly relieved. She had, however, frequent attacks of

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dyspnœa with violent palpitation, cold sweats, and cramps in the hands. These attacks were generally induced by indigestable meals and by mental emotions, and were usually relieved by chloric ether with laudanum, and placing the hands in hot water. She was improving in strength, and, in the middle of August, was able to take an airing in a bath chair. At this time a fresh attack of bronchitis supervened, which was treated with antimony and blisters, and soon relieved. Her debility, however, increased; the attacks of dyspnœa became more frequent and alarming, and she died on the 18th of October.

Post-mortem examination sixteen hours after death.—The body was much emaciated, the intercostal spaces being filled up.

On opening the abdomen, the stomach was observed to be much distended with gas; but contained little else. The intestines were also nearly empty. The stomach and intestines were healthy, as were also the heart and kidneys. The chest was found to contain, on the left side, several pints of serum, but no adhesions; on the right side, the adhesions were numerous, and of old standing, and about a pint of serum was contained within it. The auricles of the lungs were filled with thick mucous secretion. The heart was considerably enlarged, the walls of the left ventricle being considerably thickened; and within the substance of the mitral valve were two bony deposits, one as large as a full sized hazel-nut, but the other about two-thirds that size.

Mr. J. Part, *20th of January*, 1857.

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15. *Case of Mitral Valvular Disease.*

J. D., æt. 19, a groom, of temperate habits, was admitted into the Victoria Park Hospital, under the care of Dr. Peacock, on the 21st of November, 1856. He stated that he had suffered from rheumatic fever, but the precise time at which the attack occurred was not ascertained. For a considerable period he had been liable to cough and palpitation on exertion. About a week before his admission into the Hospital he was seized with pain in the left side of the chest, dyspnœa, and cough; and, at the time, he complained of a frequent severe cough, attended

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with expectoration, partly viscid, and partly frothy. He had such urgent dyspnœa, that he was incapable of lying down; his cheeks were flushed; the lips and nose very livid, and the extremities cold. The pulse was one hundred and five, and soft. On examining the chest some deficiency of the resonance on percussion was found beneath the left clavicle, and, on auscultation, subcrepitant rhonchus was audible in the dorsal regions, and sibilant and sonorous rhonchus in other parts of the chest. The præcordial region was unduly prominent; the dulness on percussion commenced at the level of the third cartilage, and became entire at the fourth, whence it extended to the edges of the false ribs. Laterally it reached from the left side of the sternum, to a finger's breadth beyond the line of the nipple. The action of the heart was irregular, and a systolic murmur was heard most distinctly below the nipple, and thence towards the left axilla. It was indistinctly audible to the right of the upper part of the sternum, but was heard on that side of the lower part of the bone. It was also feebly audible at the lower angle of the left scapula posteriorly. He was directed to have leeches applied to the præcordial region, and to take small doses of the potassio-tartrate of antimony, nitrate of potash, colchicum, and hyoscyamus, with one grain of calomel, and six of Dover's powder every night.

On the 24th a blister was applied, and, on the 27th the calomel was discontinued, and senega and ammonia prescribed in the place of the antimonial mixture. On the 6th of December he was considerably relieved from the bronchitic symptoms, and was directed to take the tincture of sesquichloride of iron, with other diuretics and anodynes. On the 21st he had been declining for several days, and was altogether much worse; the dyspnœa was more urgent, and the extremities which had previously been somewhat swollen, were more decidedly œdematous. The liver was enlarged and painful, and the urine contained albumen. The calomel and Dover's powder were resumed. On the 30th the enlargement of the liver was still greater, and there was much tenderness on pressure, with pain and distension of the abdomen, and the urine was more albuminous. Leeches were applied to the hypochondrium, and produced some relief. On the 6th of January he was much worse, and had bloody expectoration.

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On the 9th he passed much blood by stool, and the dyspnœa and other symptoms continued to increase. He died on the 11th, being sensible to within twenty minutes of the fatal event.

The body was examined by the house-surgeon, Mr. Cousins, about twenty-four hours after death.

The bases of both lungs were attached to the diaphragm by recent exudation, and there were also slight adhesions elsewhere. Each pleural sac contained about a pint of serum. Both lungs were much engorged, did not crepitate naturally, and felt solid, especially posteriorly and inferiorly, while they were slightly emphysematous above and in front. The left lung contained, at the lower margin of the upper lobe, two considerable apopletic effusions. The mucous membrane of the larger tubes was much engorged, and the tubes were filled with frothy mucus.

The pericardium was healthy. The heart displayed two large white patches on its anterior surface; the organ was greatly hypertrophied and diluted, weighing twenty ounces and a half, avoirdupois. The cavities of the right ventricle and auricle were enlarged, and the walls of the former unusually thick. There was some thickening of the tricuspid valves. The left auricle was also large, and its walls considerably hypertrophied, and the lining membrane was opaque and thick. The mitral aperture was contracted, admitting only of the passage of a ball twenty-four French lines in circumference. The cavity of the left ventricle was also large, and the muscular substance much increased in thickness. The aortic valves were thicker than natural, and somewhat opaque, but were not otherwise materially diseased. The aorta was healthy.

Dr. Peacock remarked, that the interest of the case chiefly consisted in the unusual size and weight of the heart. Of the cases of uncombined mitral valvular disease in which he had weighed that organ, he had found none in which the heart had attained so great a weight as the present; the heaviest organs having been seventeen ounces and one-eighth, avoirdupois, in a man of thirty-six years of age, and eighteen ounces in a female of twenty-one years. Indeed, in uncombined mitral disease of ordinary duration, he stated that the weight of the organ is not very materially heavier than natural, for the left ventricle does not become

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much hypertrophied or dilated, and even great dilatation and hypertrophy of the right ventricle does not add much to the weight of the heart. When, however, there is aortic valvular or aortic disease, the enlargement involves also the left ventricle, and then the weight of the organ is much greater. When also the mitral valvular obstruction is of long duration, the left ventricle partakes in the enlargement; in consequence of the obstruction in the systematic and pulmonary capillaries, and the venous system generally, interfering with the free flow of blood through the arteries. The same result also occurs when the mitral disease is combined with chronic bronchitis. In the present instance he conceived the great weight of the organ to have been due to the latter cause. The amount of increase in the weight of the heart could be estimated, when he stated, that naturally, it should not have exceeded nine ounces, or, at the utmost, nine ounces and a half, instead of being twenty ounces and a half. The mitral aperture, though contracted was much less so than he had often seen; it measured, in circumference, twenty-four French lines, and might be estimated as reduced to fully one-half its just capacity; but he had examined cases in which the mitral aperture had a circumference of only twelve and eighteen French lines.

Dr. Peacock, 20*th of January*, 1857.

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16. *Large Aneurism of the Ascending Aorta pressing upon the Right Ventricle and Auricle.*

This case was under the charge of Dr. Barnard, and was also seen in consultation by Dr. Steavenson of Hastings, and the preparation was forwarded to Dr. Peacock by Mr. Penhall. Dr. Steavenson gave the following account of the case:—

"H. C., æt. 42, a boatman, of muscular form, florid complexion, and broad chest; was first taken ill about two years ago, being attacked, on landing his boat in the evening after a hard day's work, with severe pain in the left side of the chest and difficulty of breathing. As he previously had occasionally suffered from rheumatic symptoms, he thought the pain was of a similar character; he had medical advice, and was treated for stomach derange-

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ment and got better, though never quite well. He followed his employment till he came under Dr. Barnard's care about three months before his death."

"Dr. Steavenson first saw him on the 26th of September, 1856. He was then suffering from ascites and general dropsy, with great dyspnœa, and blueness of the lips and tips of the fingers. Upon applying the stethoscope over the middle of the sternum, a powerful bruit was distinctly heard, and the heart's impulse was sufficient to raise the instrument off the chest, though the pulse was small and quick. The same method of treatment which Dr. Barnard had pursued was continued, namely digitalis, calomel, and other diuretics, and a large blister was applied over the heart. Dr. Steavenson did not see him again until the 8th of November when the abdomen was found much distended; there was hydrothorax on the right side, and the heart's action was more embarrassed, the pulse regular and weak, but without intermission. He died on the 11th of November."

"The *post-mortem* examination took place twenty-three hours after death. There was extensive effusion into the abdominal cavity; the liver was large and fatty; the right lobe reached high up into the chest, and the left lung was much displaced upwards. There were very strong pleuritic adhesions on the left side, and the lungs were congested, but otherwise healthy."

The aneurism originates from the right side of the ascending aorta, immediately above the attachments of the right and posterior aortic valves. The orifice is oval, measuring about one inch and a half from above downwards, and one inch and a quarter from side to side; the margins of the aperture, and especially the lower margin, are much indurated and thickened. From the orifice the aneurism expands greatly, forming a large sac, the base of which rests upon and compresses the fundus of the right ventricle, while posteriorly it presses upon, and must have protruded into, the right auricle. The right or outer margin of the sac forms a convexity measuring eight inches and a half in length, while across the broadest part, from before backwards, the tumour measures seven inches. The pericardium is entirely adherent upon the outer surface, and at the point at which the two surfaces of the pericardium become united, there is a wide ring of

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bone which is hard and thick, and entirely encircles the heart; towards the apex, the pericardium appears only to have adhered in places.

The walls of the aneurism are thick and firm, and lined by large, irregular, and rough plates of bone, and its cavity contains some laminated coagula not discolourized. The right auricle is dilated, and the walls of the right ventricle somewhat thickened; the left auricle was natural, and the left ventricle dilated, and its walls somewhat hypertrophied. The mitral valve was thickened and opaque, and the aortic valves are much thickened, and their edges readily admit of retroversion, so that during life they probably allowed of regurgitation.

It is rare that an aneurism originating immediately above the aortic orifice, attains so large a size as in this case; the sac most generally rupturing into the cavity of the pericardium at an early period. In this instance that termination had probably been prevented by the pericardium becoming adherent to the surface of the tumour. The case was also interesting from the pressure which the sac must have exercised both upon the right ventricle and right auricle, though the muscular walls of those cavities retain their natural thickness; and there is no probability that, had life been prolonged, any commution would in a short time have been formed between either of their cavities and the aneurismal sac.

Dr. Peacock, *20th of January*, 1857.

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17. *Aneurism of the Ascending Aorta, fatal by Rupture into the Pericardium.*

The patient was a robust man, æt. 40. Formerly he had served in the army, but, was, at the time of his death, in the Police force. He had been more or less indisposed for upwards of two years. The earliest symptoms were cardiac pain, extending up the aorta, and darting through the breast, and down the arms; palpitation, with occasional cough and difficulty of lying upon the left side; gradual loss of weight, and sallowness of complexion supervened. Almost the only physical sign detected at this period, was marked intensification of the second sound of the

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heart to the right of the sternum. Some months subsequently, in addition to these phenomena, pulsating tumour, with systolic and diastolic impulse, was detected between the second and third right costal cartilages. Compared with the cardiac impulse, sensible retardation of the radial pulse was manifest; no fremitus was felt over the tumour, but percussion yielded a dull note. The first sound of the heart heard over the apex was dull, as also over the tumour; the second sound, in this latter situation still retained its unnatural accent. The cardiac impulse was slightly heaving. A few days before the sac gave way, the first sound over the tumour changed from a dull sound, into one accurately imitated by the crumpling of parchment. Death was instantaneous in the midst of active duties. Upon dissection, a sacculated aneurism of the aorta was found, commencing about one inch and a half above the arterial valves. The sac was bilocular; the common aperture large. One loculus ascended upwards and forwards, its outer surface becoming fused with the sternal periosteum and partially eroding this bone at its right inner edge. The second loculus extended downwards and backwards moulding itself upon the cava, and thus preventing serious pressure upon the vessel. Of this lower sacculus, a transverse rupture three-quarters of an inch long had suddenly occurred midway between the right auricular appendix and the reflection of the pericardium, permitting the escape of about twenty-eight ounces of blood into the pericardial sac, and thus, probably at once arresting the heart's action. The aorta was greatly dilated at its origin, and had undergone extensive degeneration of its inner and middle coats; the walls of the heart were in a state of fatty degeneration, those of the left side being hypertrophied; the right lung was partially adherent to the sac; traces of old pericarditis existed, and the apex of the right lung presented tubercle in a state of obsolescence. The case is interesting from the rarity of an aneurism with external pulsating tumour bursting into the pericardium. From an inspection of Dr. Sibson's tables, it appears to have occurred only once in thirty-three cases.

Dr. John Cockle, *20th of January*, 1857.

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18. *Aneurism of the Aorta, involving the Right Coronary Artery, which burst into the Pericardium, and caused Death by gradual Hæmorrhage.*

J. F., æt. 38, builder's labourer, subject to fits of gout or rheumatism in his feet, but never had suffered from any symptoms referrible to the heart. When recovering from one of those attacks, and while making water in the semi-recumbent posture, was seized with a sudden pain and prostration, but without insensibility, which proved fatal in about fifteen minutes.

The chest only was examined. The lungs were quite healthy. The heart, rather enlarged, with its right cavities dilated, was quite empty, and flattened by the pressure of a clot of blood, half a pound in weight, which completely surrounded it, and which, with about four ounces of bloody serum distended the pericardium. The heart was more covered with fat than usual, but seemed quite healthy in structure. The aorta was dilated immediately above the valves, which were quite perfect, and its lining membrane, a little above the sinuses of two of the valves, had a rough corrugated appearance as though it had been ulcerated and cicatrized, but all three coats were present, at the base of the convexity of the arch; however, the vessel was dilated into a pouch, in the thin red walls of which the middle coat could not be detected; and at the place of the right coronary artery, an irregular roundish opening, the size of a sixpence, led from the aorta into a cavity that would contain a walnut, having several anfractuosities. From one of these a minute ulcerated aperture led into the pericardium, and caused the death of the patient by gradual hæmorrhage. The arch of the aorta was covered with small patches of atheroma.

The symptoms and appearances in this case closely resembled those in a similar instance brought forward by Dr. John Ogle last session, and described at p. 102 of the "Transactions."

Dr. Ogier Ward, *3rd of February*, 1857.

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19. *Clots in the Left Middle Cerebral Artery and Innominate Artery; Disease of the Aorta; Aneurisms of the Aortic Sinuses.*

A female, æt. 50, the subject of the following history, came into St. Mary's Hospital on the 4th instant. She walked into the Hospital, and gave the following account of her previous condition, thereby showing, that at this time there existed no paralysis either of sensation or of motion. She stated, that when very young she had suffered from some severe affection of the chest, and had ever since, from time to time, been in an ailing condition. The chief symptoms which troubled her were palpitations, cough, and a feeling of constriction of the chest. From the circumstance that old organised adhesions of the pericardial surfaces were found after death, and from the nature of the symptoms here mentioned, we may presume that this attack was one of pericarditis. Latterly these symptoms had increased in severity, and had incapacitated her for performing any hard work; in addition, she had also frequently had attacks of faintness and giddiness, particularly in cold weather, and on exertion. Occasionally, indeed, when out walking in the street she had been forced to cling to the walls or railings for support; and on account of her staggering gait she had been several times unjustly accused of being drunk. These symptoms increased in severity, and her breathing in particular being very difficult, she sought relief in the Hospital.

On her admission, her lips were blue, her breathing very hurried, and the veins of her neck were much swollen. It was also remarked that the pulse at the right wrist was imperceptible. At this time she was perfectly sensible, and had perfect command over her muscles. She took her dinner and went to bed; and in about an hour afterwards was found lying low in the bed, on her back and insensible. Her right arm and leg were completely paralysed, presenting not the smallest rigidity when raised or moved. The pupils of both eyes were firmly contracted and immovable. The pulse at the right wrist was not perceptible, neither was any pulse to be felt in the arteries on the right side of the head and neck; I fancied, however, that I felt a very slight pulsation in the upper part of the right bra-

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chial artery. Occasionally, during her heavy breathing, the right cheek was puffed out.

Loud rales were heard over the front of the thorax; the breathing was very noisy, so that it was not easy to make a very careful stethoscopic examination of the heart's sounds. I satisfied myself, however, of the existence of a diastolic aortic murmur—a bruit, coincident with the diastole of the heart, being audible from the middle of the sternum down to its lower edge.

The arrest of the circulation through the vessels supplied by the arteria innominata, the diseased condition of the aortic valves indicated by the bruit, and the suddenness of the paralysis caused me at this time to hazard the conjecture that a clot of fibrin had suddenly arrested the circulation through some one of the cerebral arteries—a conjecture which was fully justified subsequently.

The difficulty of breathing gradually increased, the paralysis and other symptoms remaining the same, so that the patient died about sixty hours after the first occurrence of the paralysis.

Post-mortem examination.—When the body was examined, the limbs of both sides were found of equal rigidity; there was no œdema, and but little fat on the surface; the superficial tissues were remarkably dry and bloodless. In both pleuræ there was a considerable quantity of serous effusion; the lower lobe of the left lung was thereby compressed and rendered nearly solid; the right lung was adherent at its apex, which contained a few old, small, tubercular nodules. The lungs were highly congested with bloody serum. The surfaces of the pericardium were everywhere firmly adherent by old and organised attachments. The roots of the aorta and pulmonary artery were matted together; and so likewise were the auricles. The heart was slightly dilated and hypertrophied; its aortic valves were thickened and slightly shrunken, and thereby rendered incompetent; water, when poured into the aorta, escaped freely through them into the left ventricle. The other valves were quite healthy. The arch of the aorta was dilated, and its internal surface much diseased, exhibiting everywhere signs of

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fibroid and atheromatous degenerations. In the aortic sinuses were found the openings of three small aneurisms. One, situated above the left coronary valve, admitted the little finger, and led into a pouch which passed behind the pulmonary artery towards the appendix of the left auricle. The openings of the two other aneurisms were at the right of the aorta, and situated above the right coronary valve; one was of the size of a filbert; the other was much larger, and pressed considerably upon the descending cava and the right auricle; the descending cava would not admit the entrance of the little finger.

The arteria innominata was found completely blocked up, for the last inch of its course, by a firm, whitish-red, hardish coagulum, strongly adherent to the walls of the artery, and extending up the whole length of the common right carotid. The opening of the left carotid artery at the aortic arch was not more than one-fourth of its natural calibre; being contracted by hard fibroid exudation into its coats. The left subclavian artery was healthy.

When the dura mater was opened, blood flowed rather freely from the venous sinuses. Many red points appeared on the cut surfaces of the brain, and a considerable quantity of clear serous fluid was present in the lateral sinuses of the brain. The left carotid artery, where it emerges from the sella turcica and passes to the brain, was found completely blocked up by a firm reddish coagulum, which extended for an inch along the middle cerebral artery. The portion of the brain to which the middle cerebral artery—the chief branch of the internal carotid—is directed, and particularly the left corpus striatum was much softened, readily breaking down into a pulp. The other parts of the brain, and likewise the vessels at its base, were found quite healthy in appearance.

There was nothing worthy of note to be mentioned concerning the other organs of the body.

Remarks.—This case presents some points of interest, both in a physiological and in a pathological sense. It appears clear that the arteria innominata was blocked up at the time of the admission of the patient into the Hospital, and for the reasons

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that the pulse was then imperceptible at the wrist, and that the clot itself was evidently not of recent formation. Consequently the functions of the brain were duly carried on, notwithstanding that its supply of blood through this artery was cut off, and that not more than one-fourth of the due amount of blood could have passed through the opening of the left common carotid. Also it is evident, that for the last sixty hours of life the only supply of blood which the brain received was that which passed through the left vertebral artery. The cause of the formation of the clots in the arteria innominata, and in the left cerebral artery, must be, to a certain extent, matter of conjecture. There were no local alterations perceptible in the vessels themselves which could give any account of clots. Both vessels, to all appearance, seemed perfectly healthy; the arterial branches at the base of the skull, and around the obstructed artery, were quite natural to the eye. Perhaps the existence of the aneurisms may give us a clue to the obstruction of the arteries. It is not unfair to presume that it was very possible for some broken down portions of fibrin to have been washed out of one or other of the aneurisms at the root of the aorta, and to have been carried along in the current of blood until arrested in their progress, acting then as a ligature of the artery, and causing behind it the formation of a firm fibrinous coagulum. This supposition is strengthened by the fact that the mouths of the aneurisms were large. There were no fibrinous beads around any of the heart's valves, so that the carrying away and arrest of one of these in the circulation could not have caused the clots, after the manner described by Dr. Kirkes. The softening of the brain was clearly secondary to the arrest of the circulation. In this case the supply of blood to the left middle lobe of the brain must have been wholly cut off; there could have been no compensatory supply to it through the right carotid artery.

To the practitioner, also, this case of paralysis, like so many others of its kind, offers a word of fruitful warning. What would a vigorous treatment have done here? What could any interfering treatment do?

Dr. W. O. Markham, 17*th of February*, 1857.

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20. *Fibroid Degeneration and Enlargement of the Heart without Valvular Disease.*

L. W., æt. 34, was a patient of Dr. Barlow's, in Guy's Hospital, in February, 1857, and died soon after admission. Her husband stated that when twelve years of age, she had an attack of acute rheumatism, and had always been a delicate, ailing woman. She had had also numerous miscarriages. During the last few weeks she had been suffering from all the usual symptoms of heart-disease. The bronchial rales obscured the cardiac sounds, but no very evident bruit was heard. The urine was albuminous. The body presented the usual appearances of one dead of heart-disease. Lower limbs dropsical, upper part of body yellowish, and face congested. The viscera were hard; liver nutmeg; subacute inflammation of the bronchial tubes; kidneys appeared to the naked eye healthy, but the microscope showed some inflammatory deposit within the tubules; there was probably a recent or subacute inflammation of these organs. The heart was enlarged, weighing twenty-two ounces, and the left ventricle disproportionally increased, thus giving it a resemblance to the form seen in aortic disease. This cavity was considerably dilated; the walls, which were of the natural thickness at the base, gradually diminishing until they were nearly lost at the rounded apex. The right ventricle was enlarged, and walls hypertrophied. All the valves were healthy, but the mitral orifice was perhaps slightly larger than natural from the stretching which it had shared with the ventricle. The remarkable peculiarity, however, about the heart, and that which constituted its essential disease, was the fibroid degeneration it had undergone in consequence of a general inflammation of all its structures. Thus, the pericardium was of an opaque white colour, and much thickened. The endocardium, in like manner was similarly affected, and this was especially the case at the lower part of the left ventricle, where the serous membrane formed a milk-white dense structure covering the inner surface of the cavity, and completely surrounding the muscular columns. The smaller muscular trabeculæ were wholly converted into fibrous cords, and the larger, when cut across, were seen to consist of a dense fibre

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structure externally with remains of the muscular tissue within. The great peculiarity, however, in this diseased organ, was the fibrous degeneration of the muscular walls themselves; thus, if any part were cut through, the structure was seen to be pervaded by a number of white lines and patches; these consisted of fibre-tissue, and affected every part of the organ; the right ventricle being also involved, although its endocardium was healthy. As far as could be estimated, one half at least, of the true muscular tissue was thus displaced by the adventitious fibre.

The same question arises in this case as in most others of heart-disease, where there is a history of rheumatism several years before; how much of the disease occurred at that time, how much was altogether recent, or how much was essentially chronic, and required years for its production. No doubt the disease in this case would have taken a different course if the severity of the endocarditis had alighted, as is usual, on the valves and their neighbourhood.

Dr. Wilks, 17*th of February*, 1857.

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21. *Rupture of the Right Posterior Cerebral Artery. Death from Hæmorrhage. Extensive Disease of Kidneys.*

A. W., æt. 69, was found dead in bed, about nine A.M., on Thursday, the 5th of February. Her occupation for some years had been that of a crossing-sweeper; but she was also in receipt of an allowance of money from the parish. She was not in want of the necessaries of life; her habits were intemperate, and she principally drank gin. She was stated, by her neighbours in the same house, to have suffered from rheumatic gout, particularly in the hands; and occasionally from convulsions, which, from the best accounts that could be gathered, appeared evidently to be epileptic.

Post-mortem examination, ninety-six hours after death, by Mr. H. C. Stewart.—Externally there were no marks of violence; the body was not emaciated, but rather the contrary, the face was distorted and drawn to the right side, the mouth partly open, the top of the tongue protruding, and shewing marks of having been bitten; a bloody serum was exuding from the mouth; the hand,

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arm, and leg of the same side were more contracted than those of the opposite side.

Head.—On opening the skull, the dura mater was found highly congested, and on cutting into the cavity of the arachnoid, a considerable quantity of watery fluid (two ounces by measure) escaped. The pia mater was likewise much congested. The substance of the brain was firm to the touch, and when cut into, exhibited throughout a high state of vascularity. The left lateral ventricle contained about half an ounce of serum; the right one contained about the same quantity, but in the anterior part of it was a large clot of blood, which was traced into the third ventricle, thence into the fourth, and ultimately to the base of the brain. This clot was sufficient to fill an ounce measure. The source of it was from the right posterior cerebral artery, which was ruptured. The base of the skull contained two ounces of bloody serum. The cerebellum itself was healthy, but its vessels very congested.

Lungs healthy, except slight costal adhesions of the right one. Heart of natural size; externally, rather large deposit of fat around the coronary vessels. No valvular disease of either side. Walls of about usual thickness, but, perhaps, less firm than natural. Stomach, containing about three ounces of semi-digested food, apparently broth and potatoes; lining membrane perfectly healthy. The liver, spleen, pancreas, and intestines presented nothing worthy of note. The left kidney was small, measuring three inches and a quarter in length, and one inch and three quarters in breadth, being one inch and one-eighth thick; a number of cysts were seen through the capsule, which, on being removed, brought away with it some portions of the kidney-substance; the surface, besides presenting a large number of cysts, was rough, granular, and mottled with a slightly yellowish tint. The cysts varied in size from the minutest point just visible, to three-eighths of an inch in diameter; they existed in the kidney substance, as well as on the surface, beyond the level of which they projected very slightly, and were more abundant and larger at the upper than at the lower end of the kidney; they were filled with a thin, slightly yellowish-brown fluid, which varied in tint in the different cysts. The right kidney was yet smaller than the

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left one, but the cysts in it were more numerous, and larger. The kidneys presented very good specimens of granular disease, combined with cystic degeneration of those organs.

Dr. Hare, *2nd of March*, 1857.

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22. *Open Foramen Ovale; Loud Systolic Bruit; Tuberculosis of the Lungs.*

C. S., æt. 4, had always been considered a delicate child. A year ago, she was, for some cause, under the care of my friend Dr. Sievcking, but had since then enjoyed good health up to the period of my seeing her. On the 7th of February, 1857, the child was brought to the Hospital by the mother, who informed me that she had been ill about three weeks, that she was falling away, had become thin and pale, had lost her appetite, and was occasionally sick; that she was also fretful and irritable, and had an occasional slight cough. On examining the chest, I found a rough, loud, systolic bruit, which was audible all along the base of the heart, and in the whole of the left subclavicular region; it was indistinctly heard below the nipple, and was scarcely audible at the heart's apex; its point of greatest intensity was to the left of the upper part of the sternum; it was not audible up the right edge of the sternum, along the course of the aorta. I found nothing abnormal in the sounds of the lungs, excepting only that I believed the subclavicular region of the left side was slightly duller, on percussion, than that of the right side. Taking into consideration the general condition of the child, the peculiar situation of the bruit, the absence of all symptoms of cardiac disease, and the possible presence of a left clavicular dull percussion sound, I formed the diagnosis that the child was suffering from tubercular disease of the lungs; though at the same time, on account of the absence of other signs and symptoms of pulmonary disease, I placed a query by the side of the diagnosis entered on the paper.

During the following ten days, under the use of cod-liver oil, and steel, the child appeared to improve in health. On the 18th however, about twelve days after I had first seen her, she was brought to me greatly altered in appearance. The mother

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informed me that, on the preceding evening, the child (who, up to this moment, seemed still improving) had been suddenly seized with violent convulsions and great difficulty of breathing, and that she had been struggling and fighting for life the whole of the night, the mother expecting that every moment would have been her last.

It was evident now that some serious mischief had fallen on the brain. Instead of being, as hitherto, restless and irritable, and hard to manage, she lay in her mother's arms, sleepy and drowsy, stupid, difficult to rouse, and partially senseless. There were also convulsive twitchings and jumpings of the right shoulder, but no paralysis. The face was flushed, the pulse rapid, and the skin hot and dry. There was no cough, nor was the respiration particularly affected; she breathed freely, in fact. On examining the chest, I found the heart's action violent: the bruit mentioned above was still present, but it was now louder, rougher and more prolonged; it was distinctly audible over the whole præcordial region, also over the upper part of the sternum, and along its right border. It was also heard remarkably loud in the whole of the upper half of the interscapular space—equally loud on either side of the spine. The lungs were carefully examined, but nothing abnormal could be detected in any portion of them. A note was made at the moment, that the respiratory murmur was everywhere loud and clear, and the percussion-sound good. Not the slightest rale was anywhere audible.

I may here observe, that the child was not altogether free from symptoms of cyanosis. It is true they were so little marked, that I should not have noticed them, had not the mother called my attention to the circumstance, that the child's feet were generally cold, and often of a blueish red colour; and that the small veins immediately around the nails of the hand were swollen and dark coloured. The serious condition of the child at the moment entirely distracted my attention from this particular fact.

Taking into calculation the signs and symptoms here recorded, I came to the conclusion that the child was now suffering from cardiac inflammation. I founded this opinion on the violence of the febrile action, the intensity and now wider distribution of

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the cardiac bruit, and the absence of signs and symptoms of pulmonary disease. The choreic twitchings of the arms, the strong beatings of the heart, and the cerebral symptoms, confirmed the opinion, that there was cardiac inflammation, and that the disease had secondarily involved the brain.

The child died about seventeen hours after I had seen her and had made the above examination.

Post-mortem examination of the body revealed the following condition of the heart and lungs. The heart presented, neither externally nor internally, the slightest trace of inflammation; nor was there, as far as the eye could judge, any deviation from their normal condition observable in any of the valves or of the orifices of the organ. There was neither constriction of the orifices, nor of the roots of the great vessels, nor any defect in the valvular apparatus. In all respects, the heart appeared healthy and normal, except in one, and this was in an open condition of the foramen ovale. The foramen ovale, though largely open, so as to permit the point of a finger to pass from the right into the left auricle, was partially closed, on the left side of the septum, by a peculiar adjustment of the membraneous valve. This membrane, about one-third of an inch wide, was attached at the upper and lower parts of the opening, but at its intermediate parts was free and unattached, in consequence of which, it would permit a stream of fluid to pass readily from the right into the left auricle; but, should the current tend to pass in an opposite direction—from the left to the right auricle—then the membrane, falling back on the opening, and acting as a valve, would prevent the flow of the fluid, excepting through two narrow semilunar slits which still remained unclosed, one on either side of the membraneous valve.

The lungs were dark coloured, and did not contract much when the thorax was opened. On incising them, I found that there was not a single portion of any lobe of either lung which was not studded with miliary tubercles. These tubercles, about the size of mustard-seeds, were equally distributed through all parts of the lungs, and were evidently deposited at a similar moment, for they all presented exactly similar appearances; they were placed at intervals of about half an inch apart. The lung-

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tissue intervening was perfectly healthy and crepitant, and readily distensible by inflation. Very little bloody serum escaped from the cut surfaces of the lungs, nor was any observed in the larger bronchial tubes.

Remarks.—Such was the history of the physical signs and symptoms carefully taken during life, and such the condition of the heart and lungs found after death, in this very interesting case. One or two points of considerable importance, affecting the diagnosis of the diseases of the heart and lungs, appear naturally to suggest themselves for consideration in connection with the history.

What was the cause of the cardiac bruit? and how came it, that, with such a large and extensive deposition of tubercles in the lungs, no physical signs of disease of the pulmonary organs were present when the chest was examined only seventeen hours before death, and that the respiratory murmur was then loud and clear, the percussion very good, and no rale anywhere audible?

When I first saw the child, I imagined that the bruit was in some way connected with, and, in fact, indicated, tubercular disease of the upper lobe of the left lung; for, as is well known, we occasionally meet with a bruit in such case at the left of the sternum, taking the direction of, and therefore supposed to have some connection with, the pulmonary artery; the hypothesis being, that the artery or its branches are at some point compressed by the swollen mass of the tubercular lung. The history and cause of such bruit, however, I may observe, are very obscure; and whether the condition mentioned be the true one or not, it is very clear, from the nature of the bruit heard in the present case, its extent, its loudness, and the position where it was heard most intensely, that it is not to the tubercular condition of the lungs that we must look for its explanation.

It seems, then, not unnatural—as the valves and orifices of the heart itself were normal, and as no change of structure could be found in the aorta, or in any of the parts around the great vessels at the root of the lungs—to suggest, that the bruit had its origin in the open foramen ovale. On any other supposition, the

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bruit seems inexplicable. But here we are met with the difficulty, that, in all cases of open foramen ovale hitherto met with in which bruits have been heard during life, there have been found (where examinations have been made after death), in addition to the open foramen ovale, abnormal conditions in other parts of the heart, or of the great vessels, such as of themselves might be considered sufficient to produce the unnatural sound.* And then, again, it is asserted, *a priori*, that, from the very nature of the parts implicated, it is scarcely possible a bruit could be produced from an open foramen ovale. Let us consider shortly the value of these two objections.

I may, in the first place, safely conclude that, in this heart, there really did exist no abnormal condition beyond that of an open foramen ovale.

If we consider the question, we shall find, that the fact of some other abnormal state of the heart having been always found present, coincidently with an open foramen, in cases where the bruit had been heard during life, does not militate against the idea, that an open foramen ovale may of itself, under certain conditions, give rise to a murmur. For is it not very possible that such murmur may have been present in many cases simply of open foramen ovale, but was not discovered during life, because the disturbances to the circulation, produced by the simple lesion, were not of themselves of a nature marked enough to excite attention? In cases, and these are the most ordinary kind, where the pulmonary artery is at the same time constricted, it is evident that disorders in the heart's action must ensue, such as would inevitably demand notice. Cases where the foramen ovale must have been partially open during life, and yet where no symptoms to mark the fact had been observed, are frequently met with; and assuredly, in the majority of these cases, it would be a complete begging of the question to affirm, that no murmurs really existed during life. It is more correct to say that, in the

* Dr. Walshe, who must be as well acquainted as anyone with the real position of the case, states in his work on the *Heart and Lungs*, p. 711:—"I do not know that we are in a position to assert positively that patency of the foramen ovale will in itself cause murmur; for in all the records that I have met with of the co-existence of the two things, either constriction of the pulmonary orifice is actually stated to have existed, or it may have existed.

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very great majority of cases of simple open foramen ovale, disturbances in the circulation do not occur, and therefore no examination of the heart is made during life. Practically speaking, how many cases are there on record, where simple open foramen ovale has been found after death, in which the observer can affirm that no murmur existed during life? I suspect, very few; and if so, then it follows, that there is no evidence positively demonstrative of the non-existence of such a murmur; and that the objections to it are purely hypothetical.

In the next place, why should we judge such a bruit to be improbable, on account of the nature of the conditions under which it must be produced? Let us shortly consider what these conditions are. It must be remembered that the bruit was heard during the time of the systole of the heart's ventricles, and must have therefore been coincident with the diastole of the auricles. A bruit arising at an open foramen, coincidently with the systole of the auricles of the heart, appears to be an impossible occurrence, for the reason that (the foramen being open, and consequently the blood in the two auricles freely communicating) the pressure on the blood during the auricular systole would be equal in both auricles, and consequently there would be no tendency of currents of blood to pass from one auricle to the other. But a very different condition of things obtains during the diastole of the auricles; then, the blood, rushing from the venæ cavæ and the pulmonary veins into the relaxed auricles, might readily find its way through an open foramen ovale, and, under certain conditions, conceivably produce such vibrations as would be represented by murmurs to the ear of the auscultator. How, indeed, can it be asserted with confidence, that, in those cases of open foramen ovale associated with other defective conditions of the heart, in which murmurs were heard during life—how can it be asserted, that none of the murmurs ever arose at the open foramen? Why is it assumed that they always take their origin in those other defective conditions, whatever they be, of the heart?

In the present case, the anatomical condition of the aperture of the foramen was plainly most favourable for the production of

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vibrations, *viz.*, a thin membraneous band stretched across the opening, and attached only at its two extremities. A current of blood rushing through such an aperture, from the right to the left auricle (and we have seen that the current could not pass from left to right) would hardly fail to throw the membrane into a vibratile state. Any impediment to the passage of the blood through the lungs, and consequently through the right side of the heart, would naturally tend to increase the flow of blood through the foramen ovale, by obstructing its ready exit from the right auricle into the right ventricle. In this case, we must suppose that the tubercular condition of the lung impeded the circulation, and so might have increased the intensity of the bruit, as it was last heard during the life of the patient.

Again, it has been objected that the force of the blood flowing into the auricle from the venæ cavæ is not sufficient to give rise, under such circumstances, to a bruit. To this I will answer, that great force in a current is not always necessary to produce a bruit, and that under a favourable combination of things a weak current may occasion a very loud murmur.

For such reasons, I think the objections to the probability of the bruit being in this case formed at the foramen ovale untenable. One argument in favour of the view I hold I have not yet mentioned, though I think it a very powerful one; it is this. If the bruit was not formed at the foramen ovale, what produced it? I certainly think it much more rational to believe, that a long and loud bruit, such as this, heard on several separate occasions (and most carefully observed) at a peculiar part of the thorax in front, and loudly also in the interscapular region, arose at the open foramen, than to acquiesce in the proposition that some inexplicable mystery involves the subject. I have given, I think, fair reasons why, *a priori*, there is nothing improbable in the existence of such a murmur; and the facts, as here related, appear to me to justify the conclusion, that a murmur so produced really did exist in the present case.

Another fact of considerable interest was observed in connection with the lungs. Seventeen hours before death, a careful examination detected no alteration whatever from the healthy state at any part of the chest, either in the percussion or

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auscultation sounds of the lungs; and yet, nevertheless, there was found, after death, no portion of either lungs in which were not thickly strewn miliary tubercles.*

Dr. MARKHAM, *3rd of March*, 1857.

Report on the specimen.—Dr. Quain reported for Dr. Peacock and himself upon this specimen, but it had been a good deal injured by previous inspection. So far, however, as it was possible to judge, there was nothing abnormal in the cavities, the inlets, the outlets, or the valves of the heart, except the open foramen ovale and the band stretched across it as decribed in Dr. Markham's communication. They were unprepared to say how far this malformation was capable or incapable of producing the morbid sound described by Dr. Markham. *17th of March.*

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23. *Malformation of the Heart. Cyanosis.*

A boy, æt. 4, died on the 28th of March. Cyanotic more or less since birth, but was not much so until one year old. Parents say that a former child suffered and died in the same way.

Symptoms of cyanosis varied a good deal in amount. When the child was in its best health and quiet, it was only slightly blueish, and extremely languid; but when out of sorts at all, it was very blue and cold, its breathing difficult, and it was unable to move. The child was very weak and thin, and at its best could only walk across a room. Appetite was very capricious; sometimes it refused all food but sugar and water, and then it had a habit of chewing brown paper. Fingers and toes were greatly clubbed.

About a year before its death, a very loud basic systolic murmur used to be audible, and was transmitted freely in all directions. The child died after a week of jaundice.

Post-mortem examination.—Child small, thin, highly jaundiced, thirty-one inches long.

Heart.—Aperture admitting little finger at base of septum ventriculorum, in such a position that the aorta arises from both

* In order that medical statistics may not be vitiated, it is proper to state that this case is also related, with comments, in the "British Medical Journal" of April 4th, 1857.—*Ed.*

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ventricles about equally. This vessel is one inch and three quarters in circumference at its origin; its valves are natural. The pulmonary artery arises from the left ventricle, and is about half its natural calibre, being only two-thirds of an inch in circumference; has only two valves, which are small, and probably incompetent. Ductus arteriosus obliterated; foramen ovale patent, about one-third by one quarter of an inch in size; mitral and tricuspid valves natural; the two ventricles of nearly the same size, and both of great thickness, contributing about equally to form the apex. Liver, seven and a half inches transversely, mottled, hepatic ramuscules injected; gall-bladder filled with whitish mucus, its lining membrane very finely injected, and its coats thickened with transparent lymph; spleen, three inches and a half, quite firm and natural; pancreas healthy; stomach rather large, quite healthy; thymus, one inch and a half, natural in texture; lungs quite healthy; vessels at roots of lungs present no obvious peculiarities as to size.

Mr. GEORGE BUCHANAN, *7th of April*, 1857.

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24. *Fibroid Growth in the Septum Ventriculorum of the Heart.*

This specimen was sent to me by Mr. Dolman, house-surgeon to the Derby Infirmary, with the following history:—

A. B., æt. 23, a cattle-drover, whilst driving a beast, at nine o'clock, A.M., in the streets of Derby, was seen to fall suddenly on his face. He was immediately picked up, placed in a cart, and carried to the Infirmary which was close by, but when arrived there, life was extinct. The person who first saw him, said he gasped two or three times, and then ceased to breathe. The *post-mortem* examination was delayed three days, in consequence of the necessary authority not having been received. The body was well nourished and muscular; all the organs were found to be healthy. The pericardium contained the ordinary amount of fluid, and was otherwise healthy; a little dark coloured fluid-blood was found in the right auricle, but the ventricles were quite empty. A large hard tumour was found to be growing in the septum of the ventricles. The heart was then sent to me for further examination.

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The organ was of the usual size, the cavities well proportioned, and the muscular walls of natural thickness. The growth projected more towards the right than the left side, so that, upon looking into the left ventricle, no tumour could be seen; the only trace of disease being a thickened patch of endocardium, beneath the aortic valves, at the part where the partition is merely membranous. Upon opening the right ventricle, a considerable projection was seen to occur from the protrusion of the septum into it, the latter presenting a convex instead of a flattened surface, and having in fact a general parallelism with the anterior wall; the ventricular cavity had thus somewhat a semi-lunar shape. The growth occupied the upper half of the septum, commencing above, at the base of the ventricles, and reaching as low as its centre. Its greatest point of protrusion was about three quarters of an inch below the pulmonary valves, where it pushed forward the inner curtain of the tricuspid, and considerably diminished the calibre of the ventricle at this spot. This was immediately detected, by placing the finger in the pulmonary artery from above, when it was found to pass with facility through the valves, but met with an impediment immediately below, from the protruding septum, and which only barely allowed the point of the finger to pass to the ventricular cavity below. On measurement, the circumference of valves was three inches and a half, but below it was only three inches. The growth posteriorly was not well defined, as it was connected with dense fibrous tissue, passing round to the right side and front of the heart beneath the pulmonary valves; indeed, one tough process, consisting of a trabecula changed into fibre crossed the anterior aspect of the ventricle. Although the tricuspid valves were quite healthy, and the auriculo-ventricular opening was of natural size, and allowed the usual measure to be passed through it, yet it could not but have happened from the inner curtain being so pushed out and stretched that some obstruction must have been produced at this orifice. Upon making a transverse section through the septum, the growth, as before said, was seen to occupy its upper part, its circumference was so blended with the muscular tissue around, that no accurate measurement could be made, but upon being handled, the harder mass, constituting the

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bulk of the tumour, was felt to be about the size of a billiard ball; the centre or focus of the deposit was about midway between the front and back of the heart, and rather towards the right side. At this spot the adventitious tissue had entirely taken the place of the muscular, and this was the case for the space of about three quarters of an inch, proceeding backwards and forwards from the centre, though less at the sides. Beyond this, it was intimately blended with the muscular tissue, forming hard nodules and tough patches, interspersed with the muscle, as seen in ordinary fibrous degeneration. Thus the new tissue did not involve the whole of the septum; as posteriorly the latter was unaffected, and anteriorly where it formed the front of the heart, the muscle was merely streaked, and this was more on the right than the left side, a considerable corner, in fact, joining the anterior wall being left healthy. The thickness of the septum where the new material was densest, measured a little more than an inch.

The adventitious tissue was very dense, and cut crisply with the knife; it presented the appearance usually seen in low-organised fibroid deposits. Where interspersed with the muscle on its circumference, it was very tough, and could only be torn out in shreds, whilst in the very centre of the mass the structure was softer, and could easily be detached in small pieces. The whole growth consisted essentially of a dense glistening albuminous material more or less fibrillated, and having, in different parts, various proportions of nucleated fibre, and of a homogeneous translucent substance. The toughest part interspersed with the muscle consisted almost entirely of a fibrous structure through which were scattered nuclei, and which on further examination, was seen to be composed of nucleated fibres, and of ordinary areolar tissue. Towards the centre of this mass there was less of this organized structure; but, in addition, large plates of a homogeneous translucent material, and, in certain spots, which were yellowish and softening, the same constituents were seen broken up, covered with granules, small particles of fat, and irregular-shaped nuclei. The whole structure was dry, and yielded no juice.

The deposit was thus seen to consist of a low-organized fibroid mass, such as is frequently seen in other parts of the body, and

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presenting no peculiarities of structure. The portions of it, indeed, which formed its circumference, and were mixed with the muscular tissue, were such as are commonly met with in ordinary fibroid degeneration of the heart. The only difficult point in the case is the cause which determined its deposition in so isolated a form, and the first explanation which would suggest itself to anyone would probably be that, as in the more usual cases of the fibroid disease, certain portions of the cardiac walls present larger masses of the adventitious tissue than others, so here the new material was altogether confined to one spot, as in the analogous instance of cirrhosis of the liver, where it is known, though in exceptional cases, that large masses of fibroid tissue are sometimes isolated, and entirely destroy the original parenchyma of the organ where they occur. In these examples, however, other parts of the viscera exhibit a like, though less, degeneration, and there is sufficient evidence of the former existence of a general inflammatory process throughout their structure; but, in the present case, the heart shewed no signs of inflammation of the serous membrane, either without or within, nor was the muscular wall of any other part in the slightest degree affected. Still, there is no absolute objection to its having originated from an ordinary rheumatic endocarditis; for since, sometimes, in such a disease, the inflammation may be very intense, and local, so as to involve the muscular tissue near the valves (and producing what, in fatal cases, has been called acute aneurism), we may very fairly imagine such a rheumatic endocarditis to have once occurred here, but, being little intense in its character, left the valves easily recoverable, while the adjacent muscular fibre being involved, a chronic change had been slowly going on there ever since. The difficulties, however, which stand in the way of supposing so local a disease to originate in an ordinary rheumatic carditis, has caused me to seek another theory in explanation, or, I should say, that the latter suggested itself at once from the nature of the tumour when first I incised it, and this is its syphilitic origin. The reasons for such opinion are these,—that similar tumours are constantly met with by the surgeon in the muscles and in the tongue of the syphilitic, and that such fibroid deposits are met with in the viscera of those

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who die of inveterate syphilis; and, in one case, especially, which I brought before the notice of this Society during the present Session, a number of small tumours having the same outward appearance with the present, as well as similar microscopic characters were found in the liver, and also fibroid nodules in the testes of the same patient. And in speaking of the latter organ, I may mention that, in a case where it was very much indurated, brought lately before the Society by Mr. Curling, and referred to Dr. Brinton and myself, the same low-organized fibrous deposit was found, and here I suggested a similar cause for the disease. In the present instance, the absence of all history gives an equal claim to any plausible supposition as to the origin of the growth.

Dr. Wilks, *7th of April*, 1857.

Report on Dr. Wilks's Case of Fibroid Deposit in the Heart.—The heart appeared to be of natural size, its valves were competent, and its muscular tissue looked, for the most part, healthy. The upper and anterior half of the septum ventriculorum, however, was excessively thick, measuring, in some parts, as much as an inch and a half. This increase of thickness was due to a tough, elastic, white deposit, which formed a considerable mass in the substance of the septum. It was of irregular shape and presented to the eye a tolerably well-defined margin, but was continuous with the surrounding muscular tissue. It was not wholly invested by muscle, but was extensively in contact with the endocardium of the right ventricle, immediately below the pulmonic valve, and in a somewhat less degree with that of the left ventricle below the aortic valves, the membrane bounding it being opaque and thickened. The fibroid deposit extended from the septum into the arch of muscular tissue, separating the conus arteriosus from the rest of the ventricular cavity, and replaced almost the whole of the muscular tissue of this part; the endocardium covering this was also opaque and thick.

Under the microscope, the diseased mass was found to consist of fibroid tissue, cells and nuclei, and tubercular matter and oil. The fibroid tissues varied somewhat in character and in amount. In some parts it consisted of exceedingly delicate and interlacing

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fibrillæ, somewhat resembling those of coagulated fibrine, while, in other parts it presented a mesh-work of fibres of comparatively large size, and such as are frequently met with in many forms of adventitious growth. In many places nucleated cells existed, the cells being of irregular size and shape, but the nuclei being of tolerably uniform dimensions, round or ovoid, and nearly as large as pus cells. But more commonly, free nuclei were met with, these bodies having much the same size and appearance as those contained in the cells. The nuclei and cells were irregularly scattered throughout the mass; in some places they were absent, in some they formed an inconspicuous element, and in others they were so abundant as almost to conceal every other tissue. A certain amount of molecular matter, and of oil in minute spherules was present everywhere, and, in some situations, very abundant. In addition to the above elements, muscular fibres, more or less changed, were found in some parts of the tumour; some were comparatively little altered, while others had lost all trace of transverse marking, but few, if any, were in a state of actual fatty degeneration. The transverse striæ of the fibres of the healthy-looking muscular tissue were generally indistinct, and many of the fibres presented longitudinal strings of refractive molecules. Still, the amount of degeneration in them was by no means unusually great.

Judging from the naked eye appearances, and from the microscopic structure, it appears to us that the diseased mass, in the above case, was the result of some deposit (probably inflammatory) which had infiltrated the muscular tissue at some not very recent period; and that there is no reason to suppose that the above case differed, in any important particular, from other cases which have been been brought under the notice of the Society as examples of fibroid degeneration of the heart.

Dr. Baly.
Dr. Bristowe.

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25. *Rupture of the Heart.*

This specimen was sent to me by Mr. Hills, of the Kent County Lunatic Asylum, Maidstone, with the following history: —

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W. B., æt. 61, had been an inmate of the Institution for twenty-four years, being afflicted with dementia. He was a muscular man, and enjoyed good health. On the 29th of March he took his meals, and appeared to be in his usual health, and went to bed at eight o'clock. The next morning, at six o'clock, he was found by the attendant, dead, lying on his right side, with his hand under his head, in his ordinary sleeping position. The bed-clothes were not disarranged, nor was there the slightest evidence of there having been any struggle. The *post-mortem* examination showed the pericardium distended by a large coagulum of blood, which had proceeded from a rent in the left ventricle. The organ was removed, and sent to me. It was of the usual size, the cavities being of proportionate dimensions, and walls of usual thickness, but the whole anterior aspect, as well as the base and the sides, were enveloped in fat. This external fat had grown at the expense of the ventricular walls, which were streaked throughout their thickness by lines of fat penetrating their tissue. The neighbouring trabeculæ within the cavity were also much degenerated, and the whole muscular wall was soft and easily lacerable. The rent was transverse, or nearly parallel with the base of the heart; it was three quarters of an inch in length, and was situated one inch and a half above the apex; it was formed on the front and sides of the ventricle. Recent coagulum was in the rupture, and about it. The coronary arteries were excessively diseased, particularly the anterior. The main trunk was converted into a bony tube, and the branches leading to the ruptured spot were, in parts, quite closed by a softening coagulum, which had been formed on and within the diseased coats of the vessel. The muscular tissue was also more degenerated at this part than any other.

Dr. Wilks, *7th of April*, 1857.

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26. *Incompetence of the Mitral Valve, produced in a peculiar way, &c.*

A house-painter, æt. 41, was admitted into St. Thomas's Hospital under my care, on the 6th of February, 1857, and remained until his death, which took place on the 18th of March. He stated that he had suffered ever since he could remember from

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debility and occasional palpitation; that, during the last ten years, his palpitation had become worse, and he had been subject to shortness of breath and pains across the epigastrium; that, during the last year his symptoms had become much aggravated, the palpitation had increased, the dyspnœa had become more severe, and anasarca, cough, spitting of blood, pains across the chest, and in the back of the neck, and tingling down the arms, had supervened; and that, latterly, he had been distressed by orthopnœa.

On admission, he presented all the symptoms that belonged to advanced heart-disease. In addition to those above-mentioned, it was found that the veins in the neck were much dilated, that the face, especially the nose, were congested and livid, and that the expectoration, was rather copious, frothy and transparent, yet occasionally streaked with blood.

The præcordial dulness did not appear more extensive than natural, but seemed to occupy a rather lower position. The pulsation of the heart was not violent. Immediately to the right of the sternum, over the third intercostal space, there was a distinct systolic murmur, and a very faint diastolic one, but no trace of the normal second sound. These murmurs were audible also along the ascending arch of the aorta, but not in any other situation. In the usual position of the apex there was a well-marked, but not a very loud systolic murmur. This diminished in intensity towards the base of the heart, but increased in loudness, along a line drawn from the point indicated to the margin of the ribs, about an inch below the xiphoid cartilage. On the left of the sternum, over the pulmonic valves, a natural second sound was distinctly recognised. Both sides of the chest were resonant, and respiratory sounds, mixed with rhonchus and sub-crepitation, were audible over every part.

Autopsy.—The weight of the corpse was eleven stone and eight pounds; its height five feet and eleven inches. There was considerable general anasarca, and some congestion of the face.

Both pleuræ were free from adhesions, and each contained about half a pint of serum. The left lung was large, crepitant, and healthy. The right lung was large, and, for the most part, crepitant; but its apex was œdematous, and about a third of the

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organ was carnified. In its upper lobe was a mass about as large as a horse-bean, of what appeared to be pulmonary apoplexy. The bronchial tubes of both lungs contained a good deal of viscid, and somewhat opaque mucus.

Pericardium healthy. The heart was large, and weighed twenty-five ounces. Both ventricles appeared to share proportionately in the hypertrophy. The walls of the right ventricle were very nearly a quarter of an inch thick at the base, and the cavity was dilated. The pulmonic valves were healthy. The orifice of the tricuspid valve was so large that it admitted of the introduction of four fingers nearly as far as the knuckles. The curtains of the valve were healthy in structure and shape, but seemed far too small to close the orifice; that curtain, moreover, in contact with the septum, and the chordæ tendineæ connected with it, were so stretched over a diffused bulging of the septum, that they looked as though they were quite incapable of performing their normal functions. The walls of the left ventricle were three quarters of an inch thick in the thickest part, and the cavity was dilated. The dilatation was particularly marked about the upper and posterior part of the septum. The aortic valve was extensively diseased, being incapable of sustaining a column of water, and the orifice barely admitted the tip of the little finger. On looking at the diseased valve from the aorta, it was seen to form a very irregular dome, in the left half of which was a radial slit, which was the sole remnant of the aortic orifice. The whole of the valves, except those portions immediately bounding the slit, were converted into a nodulated mass of earthy matter, connected by buttresses of the same material, with the margins of the aortic sinuses; and several nodules of earthy concretion, having no apparent connection with the valves, sprang from the walls of the sinuses. On examining the valve from the ventricular aspect, the disease was found to be almost entirely limited to it. But, projecting from its posterior margin, and passing obliquely downwards and backwards along the axis of the anterior curtain of the mitral valve to the centre of its free margin, and by its perfect rigidity, keeping the curtain in a semi-potent condition, was a conical nodulated mass of earthy matter, about a quarter of an inch thick,

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and rather more than an inch long. With this exception, the mitral valve was in a perfectly healthy condition; and its chordæ tendineæ and musculi papillares, were equally sound. The auricles were somewhat dilated. The aorta was healthy.

Abdomen.—The peritoneum contained about a quart of serum. The liver was large, congested, and indurated; the spleen was dark-coloured and pulpy, yet somewhat firm; and the kidneys were large, hard, and congested; but all the other viscera were healthy.

The above case, though interesting in many particulars, was brought under the notice of the Society chiefly on account of the odd manner in which incompetence of the mitral valve was produced.

Dr. J. S. Bristowe, *7th of April*, 1857.

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27. *Case of Complete Obliteration of the Thoracic Aorta.*

The specimen described in the following communication, was obtained from the dissecting-room of St. Thomas's Hospital. The subject was a male, æt. 45; he was brought from a workhouse, but no particulars as to his state of health could be obtained beyond the account that some little time ago he had been under care in Guy's Hospital, on account of chest disease. His lungs showed evidences of past inflammation. It was evident that the condition of the aorta had existed for a long time; and no doubt the collateral circulation had become sufficiently established to prevent any material inconvenience from being felt. The specimen, dissected, and in a dried state, now forms part of the St. Thomas's Museum. The obliteration is situated at the commencement of the descending thoracic aorta, just below the junction of the ductus arteriosus with the termination of the arch. In the dried state it looks as if merely a constriction of the vessel existed; but in the recent state the obliteration was seen to be complete, a ligamentous cord above half an inch in length uniting the two ends of the artery.

Just above the obliteration is a quantity of atheromatous deposit, involving at that point nearly the whole circumference of the vessel. The arch is much enlarged, as are also its three

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arterial trunks. The latter were at least double their usual calibre.

Below the obliteration, the aorta forms a bulbous dilatation, which extends about the length of two vertebræ; *viz.*, from the upper border of the fifth, to the lower border of the sixth dorsal vertebra. Its diameter is very much increased, and varies from an inch and a half to two inches. Opening into this dilatation are four intercostal arteries on each side; those of the right side are somewhat the largest, the upper one being about the size of a very large goose-quill. They are very tortuous, and gradually diminish in size from above downwards, the sixth aortic intercostal on each side, being about its normal diameter. The aorta below the dilatation is also enlarged, but begins to assume its normal calibre opposite the upper border of the ninth dorsal vertebra, having gradually dimished in size, and being thus rendered somewhat infundibiliform.

The first aortic intercostal of the right side is very tortuous; passing outwards between the third and fourth dorsal vertebræ, to the head of the fourth rib, then descending vertically to the head of the third rib, having first given off from its inner side a branch, about the size of an ordinary radial, which runs upwards along the centre of the bodies of the three upper dorsal vertebræ, and anastomoses with a branch from the inferior thyroid of the subclavian. The artery, *i.e.*, first intercostal, turns outwardly, above the third rib, gives upwards a large branch, which anastomoses with the superior intercostal of the subclavian, and then divides into two branches; one continues its course between the second and third ribs, the other is double the size, and passes through to the back.

The second and fourth right aortic intercostals are large, and divided likewise into an anterior and posterior branch; the posterior branch in each case is much larger than the anterior.

The third intercostal of this side is much smaller than the first, second, and fourth, and gives off a very small posterior branch, the greater part of the artery continuing its original course.

The first aortic intercostal of the left side has its calibre somewhat less than that of the opposite side; it is very tortuous, and

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ascends to the interval between the second and third ribs; it gives off one branch, size of small radial, which runs behind the œsophagus, and anastomoses with a branch of the inferior thyroid. It there divides into an anterior and posterior branch, the last of which forms the greater bulk of the artery, the anterior not being much larger than an ordinary intercostal.

The posterior branch of the second aortic intercostal of this side is much larger than the anterior; the other intercostal arteries of this side have their posterior branches much smaller than the anterior.

Branches of right subclavian: the internal mammary and transversalis colli are very large, and have a diameter little less than an ordinary subclavian. The transversalis humeri is also large, and takes its origin from the third part of the subclavian.

First, the transversalis colli: the posterior scapular branch takes its ordinary course along the vertebral costa of the scapula; its principal branches are directed inwards, three or four large trunks running inwards, and anastomoses directly with the large posterior branches given off from the intercostal arteries.

Second, the internal mammary: the branches given off from the outer side of this artery, which run along the three or four intercostal spaces are large, and anastomose directly with the anterior branches of the intercostal arteries. The musculo-phrenic forms free anastomoses with the diaphragmatic arteries of the abdominal aorta.

Third, the inferior thyroid is larger than usual; its glandular branches are about their normal calibre; a branch runs downwards and forwards to the œsophagus, and meets an ascending branch, given off from the first aortic intercostal.

Fourth, the vertebral is of little more than ordinary diameter.

Fifth, the inferior intercostal is about the size of the internal mammary and transversalis colli arteries; it gives off a large deep cervical branch, and then continues its course tortuously to the first intercostal space, at which point a large posterior branch is given off.

The branches of the left subclavian are given off just as on the right side, but their calibre is smaller.

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The subclavian on each side is reduced almost half the diameter it had before the giving off its trunks.

The deep epigastric on each side is very large, being about the diameter of the corresponding internal mammary; very free anastomoses are formed between it and the last-named artery. We find, therefore, that the principal communications by which the circulation was carried on are:—

Firstly, the internal mammary, anastomosing with the intercostal arteries, by means of the musculo-phrenic, and comes nervi-phrenici, with the diaphragmatic of the abdominal aorta, and largely with the deep epigastric.

Secondly, superior intercostal anastomosing anteriorly by means of a large branch with the first aortic intercostal, posteriorly with the posterior branch of the first aortic intercostal.

Thirdly, inferior thyroid, by means of a branch, about the size of an ordinary radial, forms a communication between the first aortic intercostal and this vessel.

Fourthly, transversalis colli, by means of very large communications with the posterior branches of the intercostals. The size of this artery, with its large anastomosing branches, led one to look for some obstruction.

Fifthly, the branches going to the side of the chest were large, and anastomosed freely with the lateral branches of the intercostals.

In the "Edinburgh Medical and Surgical Journal," vol. CXLIX, Dr. Craigie has collected a number of cases of obliteration of the aorta. Ten of these are separated by him as peculiar in that, first, the obliteration takes place in a definite point of the artery; namely, at or immediately below the point of junction of the ductus arteriosus. Secondly, the constriction or obliteration is formed by some change in the arterial tunics themselves, and is not caused by the pressure of any tumour external to them, or taking place in the arterial tunics. Thirdly, the obliteration is confined to a very small spot. With these ten cases the above described specimen must be classed. Evidently, the condition of the aorta had existed for a very long period, and the explanation given by Dr. Craigie of his cases, either of narrowing or obliteration, seems a justifiable one, and may be extended to the

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present specimen; *viz.*, that the obliterating action, which has taken place in the ductus arteriosus, has, from some cause or other been prolonged within the aorta.

Dr. Sydney Jones, *7th of April*, 1857.

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28. *Rupture of the Aorta, by an Accident.*

The following case occurred to Mr. Roper, of Shoreditch.

J. B., æt. 55, on the 14th of April, 1857, in the act of crossing a street, was knocked down by a cart, and before he could get up an omnibus heavily laden was driven against him. The wheel did not pass over his body, but pressed on him, and pushed him along on the ground three or four yards. He was insensible when extricated from the wheel, and died within five minutes. There was no external evidence of great injury, but merely a superficial abrasion of the skin two inches above the crest of the right ilium. Upon opening the abdomen, extravasation of blood to a very large extent was found in the mesentery. On removing the intestines and mass of coagulum, the hæmorrhage was discovered to have proceeded from a transverse rupture in the posterior part of the aorta, which was opposite the fourth lumbar vertebra, and about one inch in length. Upon slitting open the aorta, another laceration was seen about half an inch below the former, of the same extent, but only through the middle and internal coats of the vessel. There were some atheromatous patches about the seat of laceration. The body of the fourth lumbar vertebra was transversely fractured; there was very little displacement of the bone, but the two surfaces could be freely moved upon each other. No other part of the body had sustained any injury. The rupture seemed evidently to be owing to the fractured bones directly lacerating the vessels.

Mr. J. Cooper Forster, *21st of April*, 1857.

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29. *Disease of the Aortic Valves; its Etiology.*

The aortic valves were all incompetent. Two of them were partially destroyed by ulceration; and two of them also puckered and fused together at their adjoining angles, a calcareous nodule

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projecting from the upper surface of one of them. The aorta itself, and the lining membrane, and other valves of the heart were perfectly healthy. The great hypertrophy of the left ventricle was evidently the secondary results of the diseased valves; thus the original disease was limited to the aortic valves, and is clearly not of an atheromatous nature, as Dr. Markham had thought it to be during life, inasmuch as there was no history of the patient having ever suffered from rheumatism or renal disease.

On more strict enquiry made after his death, of the man's wife, it was found, that though of a somewhat scrofulous habit, this man had always been very active, and was an excellent runner; he was used, indeed, to boast of his good wind. He was forty-four years old. About eight months before his death, while running quickly on a message, he was suddenly seized with violent pain in his left side; he with some difficulty reached his home, and then the pain gradually left him; from this moment his breathing became affected. Dr. M. saw him about five months after this time, and then found clear signs of aortic valvular disease and hypertrophy.

The patient, after many severe angina-like attacks gradually sank under the ordinary symptoms of heart-disease. Is it not fair to conclude, that in this case the heart-disease dated from the time, when the valves are supposed to have been injured by the unwonted exertion? His breathing previously had always been good, and afterwards was never right. There was no other cause to account for the disease, no rheumatism, no kidney affection, and the anatomical characters of it are clearly not of an atheromatous kind. Whether valves perfectly sound could suffer rupture or injury from inordinate action of the circulating organs admits of doubt. Perhaps in this case they may have been originally weak, in connection with scrofulous taint of the patient's constitution.

DR. MARKHAM, *21st of April*, 1857.

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30. *Rupture of the Aorta.*

S. G., a thin, spare woman, was brought to St. Bartholomew's Hospital, on the evening of the 2nd of April, on account of a severe

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sprain of the muscles of the back, which she had sustained several hours previously whilst engaged in lifting a bucketful of water. No other injury was to be detected.

After remaining in bed for four or five days, the pain in the back began to subside. On the evening of the seventh day she was considered convalescent. However, about eight P.M. whilst on the stool she fell back, became suddenly blanched, and died within a few minutes.

On *post-mortem* examination, fourteen hours after death, the left pleural sac was found full of blood, partly fluid, partly coagulated. The left cavities of the heart were dilated, but this organ was otherwise natural. The aorta was greatly dilated as far as the lower half of its thoracic portion. Its walls were thrown into numerous small sized pouches, especially about the ascending part of the arch. Its walls were also the seat of the ordinary atheromatous degeneration, and were in parts soft and yielding, in parts resisting, and of a bone-like consistence; two inches and a half below the origin of the left subclavian space there was a transverse rent through the inner and part of the middle coats. This rent extended across two-thirds of the circumference of the canal. Through this opening the blood had passed between the layers of the middle coat, above, as high as the origin of the subclavian, where its further progress had been arrested by one of the bone-like plates larger than its fellows, which cemented together the walls of the vessel through their entire circumference.

Below, the layers of the middle coat was torn asunder down to the origin of the renal arteries. The intermediate branches passing from the aorta were not torn across, the blood seeming to have been turned aside at their origin by the resistance which they offered.

The space thus determined, between the layers of the middle coat, was occupied by a few shreds of fibrine, save in front and to the left, just below the origin of the subclavian, where a quantity of coagulated blood distended before it the outer and part of the middle coats in the form of an oval tumour of considerable size. At the lower part of this tumour a minute opening had allowed of the escape of the blood into the sac of the pleura. The athero-

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matous degeneration ceased at the common iliac arteries. The other organs were natural in appearance.

Mr. George W. Callender, 21*st of April*, 1856.

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31. *True Aneurism of the Left Posterior Cerebral Artery.*

This specimen was removed from a female, over 40 years of age, little of whose previous history can be obtained. She appears to have been deserted by her husband, and left with the charge of three children; for this she was incapacitated, and came under medical observation with symptoms of adynamic fever or destitution; she was not comatose. There was no paralysis, either of the extremities, of the facial muscles, or of the sphincters; the senses of sight and hearing existed, and the power of deglutition. Death occurred in a few hours.

On *post-mortem* examination nothing remarkable was noted, until, on section of the cerebrum, a rounded tumour, of a red colour, was seen pushing up the floor of the third ventricle, rising between the thalami, and encroaching on the left thalamus; some of this structure was expanded over it, and occupied the space in front of the pons Varolii, and between the crura cerebri. The tumour was very firm and dense, almost spherical; the transverse circumference being four inches; the antero-posterior, three inches and a quarter; it arose from the left posterior cerebral artery, near the basilar artery, the coats of the vessel being clearly continuous with those of the tumour. A small cavity in its lower part communicated with the artery, and a soft, dark coagulum extended forwards from this, the remainder of the tumour being filled with concentric layers of yellowish dense fibrin, denser and paler at the circumference. The basilar artery was very much reduced in size; its communication with the right posterior cerebral artery was free, but with the left not so, except by small vessels anastomosing beyond the aneurism; the anastomosis between the other cerebral arteries was remarkable, both the anterior and posterior communicating arteries being accompanied

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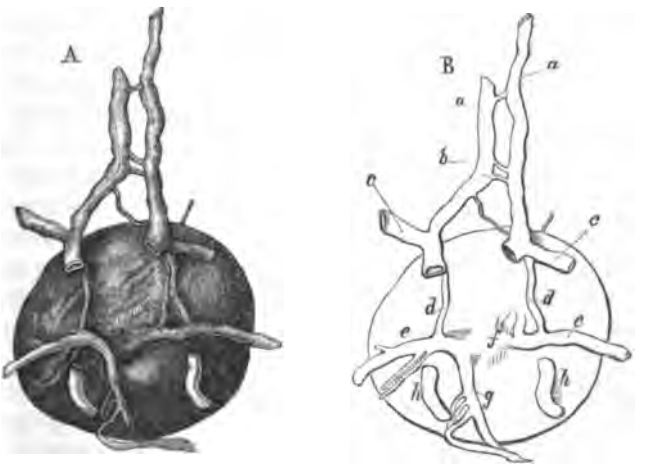
by two or three parallel vessels of nearly equal size, while similar smaller ones were noticed in the dissection. The coats of the

FIG. 8.



A. Represents the tumour of the natural size.
B. Outline.
a a. Anterior cerebral arteries. *b b*. Anterior communicating arteries. *c c*. Middle cerebral arteries. *d d*. Posterior communicating arteries. *e e*. Posterior cerebral arteries. *f*. Origin of the aneurism. *g*. Basilar artery. *h h*. Third nerves adhering to the base of the tumour.

arteries were thin, but not otherwise changed, being perfectly free from atheroma. Mr. H. SQUIRE, *5th of May*, 1857.

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32. *Malformation of the Heart, with Abnormal Distribution of Aortic Branches to the Lungs; from a Child.*

The child, which appeared to be healthy at the time of birth, had become emaciated, and died with symptoms of pneumonia, at the age of ten months. The cardiac signs before death were,—a loud systolic bruit at the base of the heart, and a very distinct thrilling pulsation felt in the supra-sternal notch. The heart was about

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the size of a large plum, divided into equal parts by the septum ventriculorum, and more egg-shaped than cordate in form. The auricles were nearly normal in size and form. The right ventricle was of full size, and its parietes were about a quarter of an inch in thickness; from it the aorta arose. The left ventricle was about the same size, and its walls were very slightly thicker than those of the right; no vessel arose from it. The septum between the two was incomplete at the upper part, leaving a space through which a large goose-quill might be passed. The auriculo-ventricular valves were normal. Owing to the opening in the septum, both ventricles communicated with the aorta, and as the pulmonary artery was so much narrowed as to have become, at its origin, practically obliterated, both ventricles must have poured all their blood into the aorta. The aortic valves were two in number, right and left, covering their respective ventricles.

Between the heart and the origin of the innominata, the aorta was so much dilated that its diameter was about twice the normal standard; but where the innominata arose it assumed the usual size which it preserved through the rest of its course. From the posterior third of the arch and from about an inch of the descending aorta, branches, three on each side, were given off to the lungs. The true pulmonary artery, which was obliterated only at its origin, sent, as usual, a branch to each lung, carrying blood supplied to it by a communicating branch from the middle of the three pulmonic branches sent off from the left side.

Dr. QUAIN for Dr. JOHN SIBBALD, *5th of May*, 1857.

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33. *Aneurism of the Superior Mesenteric Artery.*

The specimen consisted of a portion of the small intestine with its mesentery and mesenteric vessels attached. It was distant, when in situ, about two feet and a half from the pylorus of the stomach. In the main arterial branch of the mesentery, and about two inches from the walls of the bowel was an aneurism of the size of a hazel-nut, which opened by a free, rounded aperture into the arterial vessel and had given way at its anterior aspect, bursting through the anterior layer of the

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peritoneum forming the mesentery, by a very small opening, thus allowing the blood to flow into the general peritoneal cavity. A considerable amount of blood was also extravasated between the layers of the peritoneum in the neighbourhood, and the neighbouring mesenteric glands were enlarged. The aneurism contained a quantity of half-coagulated blood but no firm clot.

The specimen was removed from the body of a woman, æt. 34. She was very delicate, emaciated, and had cough, with frothy and blood-tinged expectoration, and other symptoms leading to the suspicion that she was the subject of phthisis. She suffered also from excessive diarrhœa. On the second day after admission into St. George's Hospital, she was rather suddenly attacked by pain in the hypogastric region, and died shortly afterwards, the abdomen becoming greatly distended.

On *post-mortem* examination, besides the above-mentioned appearances, the heart was found to be softened, and along the margins of the aortic and mitral valve-flaps were numbers of soft recently-formed granulations of fibrine. The lungs were rather congested, and the bronchial tubes vascular; but no scrofulous deposit was found within the lungs. Other organs presented nothing worthy of notice.

Remarks.—Dr. Ogle knew of only four other instances of aneurism of the superior mesenteric artery in man, placed on record in our English periodicals. Of these, two are described by Dr. Arthur Wilson, late senior Physician to St. George's Hospital, at p. 221 of vol. xxiv. of the "Transactions of the Medico-Chirurgical Society," one of which, by pressure upon the hepatic apparatus during life, had induced jaundice.* A third is to be found mentioned at p. 115 of "Observations on Aneurism," edited by the Sydenham Society, as described by D. Monro, who was Physician also to St. George's Hospital about the year 1760. And a fourth has been described by Dr. Elliotson in the *Lancet* for 1835, as quoted by Dr. Crisp in his work on the blood-vessels, p. 256. It was worthy of observation in the present case, that

* One of the specimens recorded by Mr. A. Wilson is to be seen in the St. George's Hospital Pathological Museum as No. 17, Series xi., sub-series v. of the New Catalogue.

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granulations of recently deposited fibrine were found on the surfaces of the cardiac valves. Dr. Ogle, not long ago, had found aneurism of one of the mesenteric arteries in the ass, containing coagulum, and numbers of the strongyli coiled round amidst the coagulum. This was in a case in which, assisted by Mr. Gamgee, he had introduced a quantity of soft coagulated fibrine during life into the commencement of the aorta. Many facts like the former have suggested to him the possibility of aneurism in the smaller arterial trunks in man being caused, in certain cases, by the presence of coagulated fibrine, either originally precipitated in the artery, or carried thither as from the valves of the heart, or from other aneurisms. A process is set up in this way, very probably, like that which occasions bulgings of the arteries occupied by the strongylus, as is not infrequently found in some of the lower animals. In the present case nothing of special interest existed in regard to the symptoms observed during life, except the diarrhœa. This was doubtless owing to some congested state of the mucous membrane in connection with the aneurism in the mesentery of the part. Possibly the congestion was attributable to interference with the nervous supply to the intestine by the enlarged vessel, and the blood extravasated into the mesentery, just as we know that injury to the cœliac plexus produces excessive secretion from the mucous membrane of the bowel with hyperhæmia.

Dr. John Ogle, *5th of May*, 1857.

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34. *Pericarditis; Extensive Effusion of Pus into the Pericardium, in an Infant aged Five Months.*

The subject of the disease, a somewhat delicate but healthy child, had been ill a fortnight only, previous to its death. For the first week the symptoms were those of remittent fever; then of a state of depression of vital powers, accompanied by desquamation of the mucous membrane of the mouth and throat, together with a slight lichenous eruption on the skin: purpura on the legs and body appeared during the last twenty-four hours of the child's life. The general symptoms that predicated the mischief taking place within the pericardium were, that within

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the first few days of the commencement of the illness, the child could not be turned or laid on its left side without evidently causing pain. At a later period it was found equally impossible to turn it on the right side; the position of greatest tranquility was the dorsal, with the trunk on a horizontal level. Any attempt to lift it into the sitting posture, or bend the spine forward gave great uneasiness, and the child spontaneously kept its spine arched rather backward. There was also, for the last few days of its life, great hoarseness, doubtless from the pressure of the enlarged pericardium on the trachea. There was also extreme restlessness, little troubled snatches of sleep only, day and night, together with almost constant elevation of the arms, and throwing about of the hands.

At the *post-mortem* examination the pericardium was found adherent to the sternum, and extraordinarily distended by fluid to the extent of flattening the left lung against the spine, and of compressing the trachea. On opening it, at least three ounces of what appeared pure mature pus flowed out. The visceral serous layer was found covered by firmly adherent villi of soft fibrin, the deep layers of which exhibited a very delicate vascular injection; these villous growths were most abundant about the origins of the vessels of the heart, and the parietal layer of the pericardium was perfectly free from them, its surface exhibiting the usual smooth and polished appearance. No endocarditis existed, nor could signs of any other disease or deposit be found in the body, except a very slight point of puriform matter just beneath the capsule in the upper part of the right kidney.

The matter discovered within the pericardium was found, under the microscope, to consist of true pus globules, together with numerous large compound cells, and fat globules, the whole contained in a fine molecular base.

Dr. Hawksley, *19th of May*, 1857.

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IV.—DISEASES, ETC., OF THE ORGANS OF DIGESTION.

I. PHARYNX, STOMACH, INTESTINES, ETC.

1. *Cancerous Ulcer of the Pharynx; Right Nervus Vagus destroyed. Dissolution of the Splenic End of the Stomach.*

A man, æt. 44, of moderately spare habit, was admitted on the 16th of October, 1856, into the Middlesex Hospital, for difficulty of breathing and of swallowing.

The larynx was prominent and fixed; although its general form was preserved, the parts connected with it were thickened, indurated, and nodulated. The lymphatic glands on each side were enlarged, of dense consistence, some adhering in clusters, others moveable, and they extended from the middle of the neck to the angles of the jaws; those on the right side being affected more than those on the left. His breathing was laborious; the inspirations being prolonged, like sighs; his voice was feeble and raucous; he was troubled with frequent cough, and he kept incessantly hawking up a brownish matter, mixed with viscid secretion. Deglutition was performed with difficulty; pultaceous food he could take down better than solids or fluids. He had suffered in his throat for six months; but during the last fortnight the symptoms had been most urgent.

He died, rather suddenly, on the third morning after his admission. On the preceding days, he had taken strong beef-tea, thickened with egg and arrow root, and wine. His nights had been sleepless, owing to the constant hawking and coughing. On that morning he had dressed, and, at his own wish, had boiled his egg himself, but before eating anything, he was seized with spasm in the throat; that attack soon subsided, and the house-surgeon, who had been summoned and speedily arrived, found him breathing in his usual manner, but extremely prostrated; in half an hour he expired.

The *post-mortem* examination was made fifty-two hours after death. In the right side of the lower part of the pharynx there was a large ulcer of epithelial cancer; part of the right ala

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of the thyroid cartilage was denuded in its centre; the ulcer, with its elevated rugged edges, involving the right arytenoid cartilage and that side of the false glottis, as far as to the root of the epiglottis. On both sides, the lymphatic glands were converted into cancer; those of the right side formed a mass, the upper part of which adhered closely to the transverse process of the vertebra dentata. The trunk of the nervus vagus, below the superior laryngeal branch, was, for two inches, embedded in the cancerous mass; and in that part of its course, the nerve was so completely converted into the same morbid structure as that surrounding it, that it could not be traced through the mass. No other deposits of cancer were found in the body.

On examining the stomach, a portion of the coats of the splenic extremity were observed to be so much thinned as to be almost ruptured. When the cavity was laid open in that situation, a part of the mucous and muscular coats, of a circular form, about five inches in diameter, was found softened and dissolved, so that the peritoneal coat alone was left entire; yet the latter membrane also had a sodden appearance. In the internal surface of the stomach generally, including the part in which the coats had been destroyed, there was an absence of any appearance of inflammation or of increased vascularity. Except a thin layer of glairy fluid, of a greyish colour, lining the surface, the cavity was empty. It was observed that the omentum, external to the affected part, was somewhat softened, and had a macerated appearance; as if, notwithstanding the peritoneal coat being entire, it had begun to suffer from the same solvent action to which the mucous and muscular coats of the stomach had been subjected.

Mr. Shaw, 21*st of October*, 1856.

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2. *Malformation of Œsophagus; Open Foramen Ovale, and Ductus Arteriosus. Cyanosis.*

The patient, a male infant, was born at the full term. The previous child had a cleft palate. Immediately after birth, a quantity of thick yellow mucus flowed from the nostrils, producing attacks of dyspnœa, with blueness of the surface, which were renewed at every attempt to feed or nurse the infant, as soon

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as it had swallowed two or three mouthsful. The cyanosis and coldness of the skin was greatest over the upper parts of the body; the legs and feet, though blue, could be kept warm, the hands and arms never. Having passed a bougie into the pharynx, I found it was arrested at about five inches from the lips; the operation caused efforts to vomit with the expulsion of thick mucus. The heart's action was normal in rhythm and sound, but the respiration was obscured by loud mucous rattles in the trachea and larynx. He died on the twelfth day, the pulse growing slower, and the body more blue and cold to the last.

Post-mortem examination.—Skin not blue, but dusky; the blood black and fluid. No coagula in heart, patches of ecchymosis in the areolar tissue of the mediastina, beneath the pleuræ, and forming hard knots in the substance of the lungs. The pharynx formed a cul-de-sac, from which proceeded a thin band of muscular fibres to the bifurcation of the bronchi, from which point to the stomach the œsophagus regained its normal size and appearance. Stomach full of meconium. On passing a probe through the stomach, up the œsophagus, it entered the trachea by a valvular opening just above the bronchi, which contained thick mucus with club-shaped, and curved, and S-shaped epithelium, that of the pharynx being flattened.

The heart was of normal size, the right auricle being, however, much larger than the left, and the foramen ovale widely open. The pulmonary artery was in contact with the aorta for the third of an inch, it then separated, gives off the pulmonary branches, and then proceeded forwards, to form the ductus arteriosus, of which the descending aorta seemed the direct continuation, rather than of the ascending aorta, the coats of which were much thinner and more flaccid, while its calibre was smaller than that of the pulmonary artery, which remained patent, the aorta being collapsed like a vein.

This case is the counterpart of one described in the fourth part of the "Pathological Transactions," in which, however, though the patient lived the same time, no notice was taken of the cyanosis, if it existed.*

* A case shewing a similar congenital communication between the trachea and œsophagus is described at p. 52, vol. vii. of the "Transactions."—*Ed.*

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There are several points of interest for consideration in this case:—First, whence came the thick yellow mucus at birth, from the pharynx, or from the bronchi? Second, the presence of meconium in the stomach. Third, the effort to vomit and the expulsion of mucus on the introduction of the bougie into the pharynx. Fourth, the greater amount of cyanosis in the upper limbs. Could this arise from a retrograde course of the arterial blood from the lungs through the foramen ovale into the right side of the heart, and thence directly along the ductus arteriosus into the descending aorta? Lastly, the patency of the ductus arteriosus and foramen ovale seemed to be a preservative effort of nature to carry on the systematic circulation, and relieve the lungs from the intense congestion that must have occurred from the frequent attacks of dyspnœa if the venous current had not been diverted from the lungs along the ductus arteriosus, and the arterial current had not been prevented from regurgitation by the foramen ovale, affording a more ready exit from the left auricle than the auriculo-ventricular opening.

Dr. Ogier Ward, *4th of November*, 1856.

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3. *Varicose Ulcer of the Œsophagus, producing Death by Hæmorrhage.*

A. C., a married woman, æt. 48, was admitted into St. Thomas's Hospital on the 2nd of September, 1856. She stated that she had been ill two months, with flatulence and other slight dyspeptic symptoms, with progressive enlargement of the belly, with pain and weakness in the loins, and subsequently with slight œdema of the ankles. On inquiry and examination, there was no evidence elicited beyond that just stated, to point out that the liver, or the kidneys, or the heart, were the seat of disease. The abdomen was considerably enlarged, but it was quite clear that the chief enlargement was due to flatus, though it was evident that a certain amount of fluid was likewise present. There was no tenderness on pressure, and nothing in the general symptom to shew that there was any peritoneal inflammation. There was little or no alteration in her symptoms up to the 16th; on that day, she had a sudden and very copious attack of

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hæmatemesis from the effects of which she died on the evening of the 17th.

Post-mortem examination.—Sept. 18th. The body was of ordinary stature, and in pretty good condition, but very anæmic. The belly was somewhat distended; the lower extremities œdematous.

Chest.—Pericardium and heart healthy; the latter was contracted and nearly empty. Both pleuræ presented a few old adhesions, and contained two or three ounces of serum. The lungs were crepitant throughout and healthy.

Abdomen.—The peritoneal cavity contained about half a pailful of clear serum, but the membrane itself was for the most part healthy. Liver, of ordinary size, and healthy, but rather pale. Spleen, four or five times as large as natural; strongly adherent to the surrounding parts, tough, fleshy, and of a pale flesh-colour. Pancreas and supra-renal capsules healthy. The upper third of the right kidney was atrophied, but the remainder of the organ and the whole of the left were healthy. There was a fibrous tumour, about as large as a filbert, in the posterior wall of the uterus, but this organ and its appendages were otherwise healthy. Externally, the stomach and small intestines were undistended, pale, and healthy-looking; but the large were dilated and much blackened. On laying them open, the stomach was seen to be filled by a soft discoloured spongy coagulum, which was moulded to the shape of the cavity, and was altogether about as large as a cocoa-nut; the small intestines were found to contain a thick brick-red grumous fluid, and the large intestine a considerable quantity of almost black and pitchy material. The mucous membrane of all these parts was perfectly healthy and pale, there was no breach of surface, and no congestion anywhere to be observed. On removing and laying open the œsophagus, the veins, immediately under the mucous membrane were seen to be enlarged and tortuous, and to possess all the characters of varicose veins. Two or three took a longitudinal course; they appeared to vary from one-third to one-quarter of an inch in diameter, and the mucous membrane over them formed a loose fold. The varicose condition was most marked at the lower part of the œsophagus. About the middle of the œsophagus was a small imperfectly cicatrized ulcer, and two inches above the

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cardiac orifice was a recent opening, about as large as a No. 4 catheter, from which protruded a small fibrinous plug, which yielded, on pressure, thin bloody serum and which communicated directly with one of the varicose veins. The margins of the ulcer were thin, and there were no visible inflammatory changes in the mucous membrane around.

Nothing was discovered in the course of the examination of the abdomen to account for the existence of ascites; nor in the examination of the chest was anything detected that could explain the varicose condition of the œsophageal veins. It must be recollected, however, that the heart and lungs were removed and examined before that state of the œsophagus was discovered, which suggested any pressure or obstruction in the course of the vein. It is possible, therefore, that some impediment may have existed, which a dissection, careful from the beginning, might have detected. It is not improbable, in the absence of peritoneal or hepatic disease, that the ascites may have been due to some varicose condition of the portal veins, originating in the same cause as the varicose condition of the œsophageal veins.

Dr. Bristowe, *2nd of December*, 1856.

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4. *Intus-susception of the Sigmoid Flexure of the Colon, and of the Upper Part of the Rectum.*

A man, æt. 40, by trade a tailor, applied for admission on account of what he said he had been told was a fistula. On inquiry, however, nothing could be ascertained from him, except that he had been suffering from alternate constipation and relaxation of the bowels for some time. Of this he had taken little notice, as he, like most of his trade, was the subject of other irregularities. For some days preceding (he said for more than a week) he had had no action of his bowels. This constipation had followed immediately on an attack of diarrhœa. He looked very much out of health, but was not particularly feeble. He was sent to bed, and laxative medicine given. There was no fistula. On the second day after his admission, as no action of the bowels had taken place, an examination was made. The sphincter was so relaxed, that it offered no resistance to the pas-

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sage of one or more fingers into the bowel. Projecting into the gut, to within about half an inch of the verge of the anus, was a soft, cylindrical tumour, of uniform consistence, smooth on the surface, and covered by the mucous membrane. The finger, when pressed up as far as possible at the back part of the gut, discovered the reflexion of the mucous membrane from the tumour to the wall of the intestine. In front, however, nothing was felt. No opening could be detected in the tumour. An exceedingly foul discharge of mucus, mixed with sanies and fæcal matter, escaped from the anus. The belly was not much distended, but tense and resonant, and a little tender to pressure. There was no vomiting, and the tongue was clean; the pulse rapid and weak. Calomel and opium three times a-day was ordered. In the afternoon acute pain was complained of in the belly, and slight sickness came on; the pulse was much weaker than in the morning. The pain increased rapidly, and, in the evening, was extremely severe. He experienced some slight relief from the application of leeches, but the pulse sunk so alarmingly, that it was necessary to give him stimulants. An attempt was made to introduce a small bougie, but it could not be passed. The pulse soon became imperceptible, the extremities and lips cold, and he died in the morning.

Owing to peculiar circumstances the examination was not made till three days after death (he died in the summer), and in a very hurried manner; only the intestines were examined. Decomposition was advancing rapidly. On opening the peritoneal cavity it was found full of semi-solid fæces. The great intestine was very much distended and very black. About the middle of the ascending colon was a large ragged perforation, from which the fæces were straining out on pressure. No other lacerations were seen in the gut at this part. The small intestines appeared healthy. The invaginated part of the great intestine was removed from the body, together with the bladder and prostate. The intus-suscepted portion measured more than three inches. The mucous membrane coating the gut was dark, and clouded in some places. A small opening existed at the apex of the protruded part, of an irregular form, with ragged edges, which proved to be that of the canal of the intestine. At the point

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where the intus-susception commenced, the gut was considerably constricted, and there a perforation existed at the anterior part, leading into the recto-vesical pouch of the peritoneum.

Mr. Holmes, *2nd of December*, 1856.

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5. Case of Intus-susception, Proving Fatal after Nine Weeks.

A. B., a fine and healthy child, four months old, and living entirely upon the breast, was suddenly seized with obstruction of the bowels and vomiting.

On the 9th of October, a small quantity of mucus and blood passed with much straining. The countenance shewed great distress, and there was extreme faintness. These symptoms lasted till the 11th, *i.e.*, three days, when the action of the bowels was restored, and the sickness much subsided, until the 28th of October, nearly three weeks from the first attack, when the obstruction, vomiting, and other symptoms returned, and continued until the 31st of October, at which time the action of the bowels again took place, and vomiting entirely ceased. The evacuations were always attended with severe straining, and on the 24th of November a portion of the bowel first protruded at the anus. This continually increased, until as much as six inches of intestine would be found down, and was with difficulty returned. Sloughing of this part was rapidly going on. The child took the breast freely and never afterwards vomited. These conditions lasted until the 11th of December (nine weeks from the commencement of the attack), when he died.

On *post-mortem* examination, the intus-suscepted portion was found to consist of small intestine (the lower part of the ilium), which had been protruded along the ascending transverse, and descending colon, and eventually from the anus. A probe passed along the intus-suscepted portion showed it to be pervious; its calibre, however, was much diminished, being about one third of an inch in diameter; and it communicated with the intestine below by an orifice of the same size; its canal was occupied by a small quantity of yellow fæculent matter, mixed with mucus; and to its lining membrane adhered some whitish flocculent lymph. The opposed peritoneal surfaces of the prolapsed portion

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were adherent along their whole extent by firm fibrous tissue. On laying open the external tube, and thus exposing the prolapsed portion, the mucous membrane of the middle tube was seen much corrugated and intensely injected. In one place (about the junction of the upper and lower valves of the intus-suscepted portion) the mucous membrane had sloughed; the sloughing extending for about an inch and a half of the length of the intestine, and involving about two thirds of its circumference, and at its lower end also the mucous membrane was sloughy, and in places removed.

Of the three tubes, the walls of the external and internal ones had their normal thickness, but the thickness of the walls of the middle tube varied from one third even to half an inch; the sub-mucous tissue being infiltrated with serum and inflammatory deposit. Dr. Sydney Jones, *16th of December*, 1856.

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6. *Passage of a Hair-pin through the Walls of the Intestine.*

The pin was from a little girl, æt. 5; there is no recollection of her having swallowed it. She first began to complain of pain in her abdomen about the commencement of 1855, but this pain became very severe about April, at which time a swelling was observed below, and to the right of the umbilicus. The swelling increased with pain and tenderness, and broke in sixteen days after its appearance. The discharge was frequently accompanied by very severe paroxysms of pain, sometimes almost past endurance; they sometimes occurred two or three times daily, but at other times not at all, having a duration that varied from two or three minutes to half an hour. During their continuance the patient constantly complained of a violent pricking pain in the abdomen; they always subsided rapidly, and the patient joyfully pursued her games till the next paroxysm. Only pus was discharged from the wound till December 1855; but at this time fæculent matter began to be mixed with the pus, and in January 1856, the points of the pin made their appearance. After a little manipulation, the whole of it was removed on the 2nd of February. Fæces continued to be discharged during the first month from the wound; the latter however, gradually contracted,

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and at about the end of another week it was entirely closed. The patient is now in capital health; cicatrices marking the site of the former wound. Dr. Sydney Jones, 16*th of December*, 1856.

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7. Fish Bone from a Case of Fistula in Ano.

The patient, a lady, recollects, about twelve months before, having swallowed a small fish bone, and for some weeks after was very uncomfortable, complaining of difficulty and pain in swallowing; this after a time, however, subsided, and until lately she suffered no inconvenience. About seven or eight weeks ago, she began to complain of uneasiness about the rectum. Pain and tenderness followed in the ischio-rectal fossa, soon succeeded by the other signs of an abscess; this burst, and on the day of its bursting, preparations were made for dividing the sphincter. The finger, passed into the rectum, detected this fish bone; one end was in the rectum, the other protruded through the intestinal walls. Two thirds of the bone (which was about an inch and a quarter in length) was in the cavity of the abscess, the remaining third in the alimentary tube.

Dr. Sydney Jones, 16*th of December*, 1856.

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8. Intestinal Obstruction, associated with a Diverticulum of the Ileum in the Left Inguinal Canal, and with Constriction, Ulceration, and Perforation of the Ileum.

G. M., æt. 42, a builder, was admitted into the University College Hospital, on the 5th of September, 1856. When a boy, æt. 9, on jumping one day over a post, he was suddenly seized with very acute pain in the abdomen, so severe that, on his return home, it caused him to roll on the floor. On being examined by a medical man, it was fouud that he had a rupture in the left groin, and from that time he wore a truss constantly, or almost constantly.

For two years past, he had not looked so well as formerly, and had frequently complained of pain in his back, but it is not known that he suffered more than usual from his rupture. It appears that on the removal of the truss from any cause, the

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rupture would come down, but could always be returned without difficulty by himself. One day, however, about ten weeks before his admission, having neglected to replace the hernia properly, he found it would not afterwards go up at all, and it was left to itself for a few days, when Mr. Noyce, of Camden Town (who has kindly supplied me with this part of the patient's history), was sent for, and found all the symptoms of strangulated hernia. He tried to return it, but without success, and (thinking an operation inevitable) sent for a surgeon, who thought he would try to return it before operating, and in that was successful; the patient got great relief, and appeared to go on well, no trace of the hernia being discovered. He, however, shortly afterwards complained of pain and tension of the abdomen with very great tenderness, and there was some tympanites, for which calomel and opium, &c., were given, and after several weeks' treatment he got so well that he used to come to Mr. Noyce (a distance of half a mile) every second morning; nearly every bad symptom had disappeared, his bowels acted freely, all sickness had gone, and his general health was improved. From that period Mr. Noyce saw nothing more of him.

It appears from the account furnished by his sister, that the patient went out occasionally to superintend his business, but that he walked slowly and stooping forward; not infrequently he was confined to his bed for a day or two. Two days before his death, he was seized with a worse attack of pain than before, and on this occasion he came under the care of Mr. Cousins, who, finding that he got rapidly worse, notwithstanding the use of a hot bath, purgatives, &c., transferred him to University College Hospital in the afternoon of the 5th of September.

I saw him at half-past four o'clock, soon after his admission. He was of good conformation; his countenance was indicative of pain, perhaps a little anxious—certainly not haggard. His surface was hot, the pulse quick; he was thirsty, and complained of much pain in the abdomen which was found to be very tender on pressure, especially over the lower part of the left side; the abdomen was much distended, but not uniformly so, there being a little flattening of the lower part of the left side compared with the corresponding part of the right side; that spot was also somewhat

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more resisting on pressure, and a little duller on percussion than the rest of the abdomen, for with the exception of that part the stroke-sound was everywhere tympanitic; besides, there was another peculiarity in the appearance of the abdomen—notwithstanding its general prominence and tension, there were two or three slight depressions or rugæ running transversely across it, separated by slight elevations, about two or three fingers'-breadth in diameter; these were caused by the distended coils of intestine. No hernia of any part was discoverable. He had had no fæcal evacuation for two days, but for how much longer the constipation had continued could not be ascertained. He retched frequently, and sometimes vomited; the odour of the little vomited matter I saw was not stercoraceous; his position was not constantly on the back, for I observed that feeling sick, he turned without very great difficulty on his right side, in order to reach a basin from the chair near his bed. Fomentations were applied to the abdomen, an enema was used, and opiates, &c., were given, but he gradually became worse, the vomited matter had a fæcal smell, and he died about five hours after admission to the Hospital.

The *post-mortem* examination was made seventeen hours after death; muscular rigidity was well marked. Abdomen appeared less distended than when seen during life, and the transverse rugæ were not detectable.

On opening the abdomen, the upper surface of the liver was seen pushed up as high as the fourth costal cartilage. Coils of small intestine, enormously distended, occupied almost the whole of the anterior part of the abdomen, and at one part a coil was distended to the amount of two inches and a half in diameter. The surface of the intestines was injected, the redness being entirely punctiform; the redness affected likewise the mesentery, and, to a less degree, the parietal peritoneum. The intestines and lower part of the abdomen were covered over with lymph of a dirty yellowish colour, on scraping off which, the surface was of a dull appearance, and rougher than elsewhere. In the cavity of the peritoneum there were about twelve or fourteen ounces of turbid fluid of yellowish colour, but doubtful fæcal odour. The intestines towards, and in the left iliac fossa were of a much deeper red colour than elsewhere; and

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on turning the coils backwards at this part, one portion of the intestines, less in diameter than the rest, and of a dark purple colour was found adherent to the parietes, just anterior to the internal abdominal ring. On examining this portion of the intestine further, one side of it was found to form a kind of knuckle or diverticulum extending into and occupying the inguinal canal, to the whole circumference of which the external surface of this diverticulum was adherent. On turning up the dark coloured coil of intestine just referred to, there was discovered, at its posterior aspect, a small perforation from which a thin, yellowish, fæcal-looking fluid escaped. The point of obstruction and perforation was three feet nine inches from the ilio-cæcal valve, and this portion of the intestine was of smaller diameter than natural; there was also, at the same part, an adhesion between the outside of the small and a portion of the large intestine. Around the perforation there existed a considerable quantity of lymph, both on the small and large intestines.

On opening the intestines, the diverticulum was found to extend one inch and three quarters into the inguinal canal, and to be so completely adherent to it as to form a kind of lining membrane for it. Just above this diverticulum, the ileum was so constricted as to measure only seven-eighths of an inch in circumference, and close to, yet still above this constricted part, ulceration of the whole circumference of the mucous membrane (for about half an inch in width) had taken place, the intestine here measuring one inch and one-eighth in circumference. It was about the middle of this ulcerated surface that perforation had occurred. Within a couple of inches above the constricted part, the ileum was so dilated as to measure four inches and three quarters in circumference.

The diverticulum was probably not congenital, but adhesion having taken place between the intestine and the parietes, close to the internal ring, or (without adhesion in the first instance) a portion of intestine having been forced into the inguinal canal, more was gradually pushed in by the vermicular action of the bowels; the diverticulum would thus be formed at the expense of the walls of the intestine: hence arose the constriction of the bowels, and, ultimately, the ulceration and perforation.

Dr. Hare, *16th of December*, 1856.

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9. *Extensive Invagination of the Small and Large Intestine. Post-mortem Destruction of the Posterior wall of the Stomach by the Gastric Juice.*

The subject from whom this specimen was taken was a female infant, æt. 6 months; she had been fed at the breast entirely, until the last week of her life, during which she had daily eaten some bread and butter; she had never had diarrhœa, or taken any aperient medicine, the action of the bowels having always been regular and natural.

On the evening of the 30th December she was suddenly seized with vomiting, and apparently great pain, which continued, but appeared to become easier during the night. I saw her first about noon on the following day, she seemed then to have pain in the abdomen, vomited occasionally, and passed frequently a small quantity of blood-stained fluid from the anus, but no fæces whatever. These symptoms continued with little variation for four days, although the pain seems to have been modified, probably by the opiate enema which was used daily.

On the 3rd of January a larger enema was administered, containing some olive oil, and two drachms of castor oil, which, according to the nurse's report, was succeeded by ten stools; there certainly was a little fæculent matter on some of the napkins shewn to me, and now no blood, but some transparent and glairy mucus. The skin was pale, and the countenance exhibited distress; there was much tenesmus; death occurred on the morning of the 4th of January, being the fifth day of the illness.

On *post-mortem* examination the peritoneum contained a few drachms of brownish serum; the blood-vessels of the small intestine were much congested, the intestine being distended with air. The cæcum could not be discovered, but on tracing the small intestine, the ileum was found to terminate in the descending colon, which was much puckered, and, together with the rectum, was distended to within two inches of the anus, with a *volvulus* consisting of a portion of the ileum, and the whole of the superior part of the large intestine. The volvulus was very dark from congestion, and the presenting part afforded to the top of the finger the same sensation as the adult os uteri.

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The posterior wall of the greater curvature of the stomach was reduced to a soft gelatinous state, and allowed the contents of the organ, about three ounces of partially digested milk, to escape on the first attempt to raise it from its position. It affords a good illustration of the destruction of the coats of the stomach by its own secretion, after death has occurred.

Mr. BALLARD, *6th of January*, 1857.

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10. *Colloid and Encephaloid Disease of the Abdomen, associated with Scirrhus of the Pylorus.*

E. C., a man, æt. 46, a native of Milan, by trade a picture frame maker, residing near Hatton Garden, was admitted a patient, under my care, at the Royal Free Hospital on the 20th of October 1856. When first seen he complained of severe pain in the epigastric region, rather to the right side, with oppressed and difficult breathing, the abdomen was swollen, and he was slightly jaundiced. The pulse was small and frequent—one hundred and ten in a minute. The patient was rather thin and had an anxious expression of countenance. On examination of the chest there could not be detected any evidence of disease of the heart or lungs; indeed those organs appeared to be perfectly healthy. I saw the patient again on the 23rd, when the symptoms were very much relieved by the treatment adopted, which consisted of purgatives, composed of compound powder of jalap with calomel—the bowels having been very much confined—with hydrocyanic acid and sesqui-carbonate of soda. On the 30th the symptoms became more urgent; the pain in the epigastrium was excruciating; the urine was scanty and high coloured; there was general dropsy with jaundice. Mild mercurial treatment, with moderate purgatives and diuretics, together with a blister to the painful part were had recourse to, and by the 7th of November, the dropsy and jaundice entirely disappeared; the only symptoms existing being pain in the epigastric region, but to a trifling extent only, and tenderness on pressure to the left of the umbilicus. The great size of the abdomen being now reduced, on a careful examination a hardness was felt occupying nearly the whole of the epigastric region, extending from the under

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surface of the liver to the left hypochondriac region, from thence descending to and filling up the left iliac fossa. On inquiry, it was found that the patient had suffered, more or less, for nearly two years, from severe pain in the epigastrium, with frequent attacks of nausea and retching, and that he had once had an attack of jaundice. He was, during these attacks, alternately an out-patient of St. Bartholomew's Hospital, and under the care of Mr. Pollock, of Hatton Garden. Mr. Pollock had, a few months ago, attended him for an enlargement of the right testicle which ultimately did well. I now viewed the case as one of malignant disease, which I supposed to be primarily connected with the stomach, and from thence extending throughout the abdomen.

On the 18th of November the patient complained of more severe pain all over the abdomen, intense and frequent thirst, constant retching, with pain and starting of the left lower extremity; the pulse was one hundred and forty; the urine scanty and loaded with urates; the tongue furred, skin hot, and the bowels constipated. Effervescing medicines, with anodyne fomentations, and mild purgatives, and afterwards anodynes internally were had recourse to with benefit. In a few days the patient vomited a quantity of fetid purulent matter, free from fæces, and the coffee-ground character usually present in those cases. The urgency of the symptoms were now very much lessened; the enlargement in the left iliac fossa became less, and the starting and painful condition of the left lower extremity nearly disappeared; the tongue was clean, and the urine was clear and abundant. On further examination of the abdomen, nodulated masses could be felt distinctly over the whole of it. The retching became more frequent, and nothing could be retained on the stomach; even a teaspoonful of cold water, or a little ice gradually dissolved in the mouth, was rejected as soon as it reached the stomach, and it was necessary to sustain the patient by enemata of brandy and beef tea. During this time there was frequent vomiting of the same purulent matter as before. In this state the patient continued until the 16th of December, when he died, a mere skeleton.

A *post mortem* examination was made thirty-six hours after

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death, by my colleague, Mr. Gant, and myself. Nodulated masses could be distinctly felt through the abdominal walls. On opening the abdomen, which contained about three pints of serum, and reflecting the parietes, the following structures presented themselves, from above downwards. The thickened diaphragm, the ensiform cartilage displaced upwards, and to the right side; a small portion of the left lobe of the liver; a nodulated mass in the situation of the omentum, concealing all the other structures, except those in the left iliac fossa, where a small portion of the sigmoid flexure of the colon touched the abdominal parietes. The reflected parietes presented nodules of colloid cancer. The organs of the abdomen were removed *en masse*, being connected together by a large, apparently colloid and encephaloid growth. Their relations to each other were altered in various ways by pressure of the growth, which had not infiltrated their structure. Thus the pyloric extremity of the stomach was dragged down, so that the longitudinal axis of that organ was more vertical than usual. When opened and viewed posteriorly, a large mass of cancer was seen, the central portion of which was scirrhus, and the peripheral colloid. The mucous membrane of the pylorus was, to a small extent, destroyed. At this part there was a very small opening which appeared to be recent. The peritoneal surface of the stomach presented nodules of colloid, but the mucous membrane was entire, except at the pylorus. The liver, especially the right lobe, was much compressed by the diaphragm, which was itself much thickened throughout its entire extent, by a layer of cancerous deposit; this layer had not superseded the muscular and tendinous structure of the diaphragm, although, from pressure, it would appear that the muscular portion was atrophied. The right lobe of the liver reached up to nearly the third rib. The inferior cava and hepatic duct were surrounded and compressed by the general mass, and the gall bladder was therefore much engorged. The structure of the spleen was condensed, from pressure of the surrounding cancer, which had encroached into its sides, with which it accurately corresponded, but the interior of the spleen was free from cancer and otherwise healthy, excepting two buff-coloured spots, the

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nature of which could not be made out. The kidneys and suprarenal capsules were healthy, but the latter were compressed and atrophied. The pancreas was identified with the general mass, which extended downwards throughout the omentum, and the transverse colon lay in a groove, surrounded, but not infiltrated, with cancer. The remaining portions of intestine, were full and unobstructed, but a few convolutions which lay across the lumbar vertebræ were reduced to almost the size of a quill. The bladder was healthy, and so were the lungs and heart, but the veins of the latter were very turgid. On microscopical examination, the growth appeared to be made up of scirrhus, colloid, and encephaloid.

In the "Transactions of the Pathological Society of Dublin" there are two cases, one by the late Dr. Greene, the other by Dr. Lees, very much resembling the case now before the Society. In Dr. Greene's case, however, there was no retching or vomiting until about ten days before death, when a coffee-ground fluid was thrown up; but there was ulceration of the stomach. The patient had been complaining nine months. In Dr. Lee's case the patient had been complaining only for nine weeks; there was no pain or tenderness on pressure; there was frequent vomiting, but no ulceration of the mucous surface of the stomach. In the current number of the "Glasgow Medical Journal" there is a similar case recorded by Dr. J. Bell, occurring in a woman, æt. 30, who died in eight months after the first symptoms were complained of. In Dr. Bell's case, besides the pylorus being a mass of scirrhus, and the omentum being also attacked, the cancerous matter infiltrated some of the abdominal organs.

My colleague, Dr. Brinton, examined specimens of the diseased masses. The yellow, transparent, jelly-like, and tremulous nodules had all the characters of colloid or alveolar cancer, consisting, that is, of a spare, delicate fibrous network, enclosing in its meshes cells of equal delicacy. Some of these cells contained highly refractive (oil?) globules; a few, pigment; many contained cytoblasts. The stomach offered appearances which were interesting as an example of a condition which he (Dr. Brinton) thought was not uncommon, and often led to ambiguity of de-

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scription. Though offering to the naked eye all the characters of scirrhus, the pyloric disease was shewn by the microscope to possess much of the structure of colloid; differing from the colloid in the peritoneum, chiefly in the larger quantity of the fibrous network between its cell-growth—a complication of the two varieties of cancer, which in some degree or other, was rarely absent from the latter stages of these gastric cancers of rapid growth. The diaphragm seemed affected chiefly by its peritoneal covering, sharing in the general involvements of this serous membrane, and it was difficult to avoid conjecturing that such a wide spread of the colloid deposit was often brought about by the effusion of a cancerous juice into the peritoneal cavity. The striking immunity of the liver, as well as that of the lungs, kidneys and other organs appeared, from his (Dr. Brinton's) researches, to be rather favoured by diffused secondary deposits in the peritoneum, like that seen in this case.

Dr. O'Connor, *6th of January*, 1857.

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11. *A Case of Direct Inguinal Hernia.*

This case occurred in the person of a male, æt. 81, who stated that he had been ruptured for eight or nine years only. He was admitted into Guy's Hospital, under Mr. Birkett, on account of strangulated hernia, of seventy-two hours duration. The bowel was liberated by operation, but the patient died in forty-six hours afterwards with acute peritonitis.

The hernial tumour passed into the scrotum directly through the external abdominal ring. Having passed the external ring, the spermatic cord was firmly attached to the sac along its inferior border, and at the time of the operation was more distinctly seen than is usual in oblique inguinal hernia.

The aponeurosis of the external abdominal oblique muscle having been reflected, the conjoined tendons of the internal abdominal oblique, and of the transversalis muscles were seen to spread over, and to be very closely united with the tissues forming the hernial sac.

The free edge of the internal oblique and transversalis muscles and their tendons having been raised and reflected upwards, the

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pubic portion of the fascia transversalis was traced downwards on to the sac.

The spermatic cord emerged from the abdomen, as usual, through the internal abdominal ring, but did not come into contact with the hernial tumour until it had traversed about one inch of the inguinal canal, or a little before it passed with the tumour through the external ring.

The pubic portion of the fascia transversalis was very strong and fibrous.

Internal view.—The epigastric artery was one inch to the outer side of the neck of the sac, but close to the internal border of the internal abdominal ring.

The peritoneal sac and sub-peritoneal uniting tissues were very rigid.

Mr. Birkett, *6th of January*, 1857.

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12. *Ulceration of the Œsophagus, communicating with the Right Bronchial Tube.*

The person from whom this specimen was taken, was a little fat man with a pendulous abdomen, but a good development of his limbs. He was æt. 61.

He lived freely until about four years since, when he began to lead a more quiet life, still taking a fair amount of wine and stimulants. His father died, æt. 73, from some disease of the bowels, not well ascertained. One of his brothers, of whom there were seven, died between 20 and 30, also from some affection of the bowels. His mother died from cholera at an advanced age.

Some years since, and before I attended him, he suffered from fistula; since which he has, on three several occasions, had abscess between the bladder and rectum. He had, also, a few years since, a troublesome cough, for which he consulted Mr. Yearsley, who removed a portion of the uvula with relief. His bowels were usually torpid, rarely acting without medicine or enemata, and he was unable to take much exercise owing to pains about his knees of a neuralgic character.

On the 30th of last March he was suddenly seized with a violent attack of hæmatemesis, when he lost a large quantity of

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blood. The liver at this period was larger than natural, being hard and painful to the touch. From this attack (which left him pale but did not reduce his size) he slowly and imperfectly recovered; his appetite being bad, his bowels torpid, and the pains about his knees frequent. In September, while at Folkestone, he began to complain of indigestion, with difficulty in swallowing, and returned home suddenly on the 16th, when I saw him. He then complained of pain at the pit of the stomach, which was diffused over the right and left hypochondriac regions, and was severe between the shoulders. The pain was increased after eating, which was attended by a sense of a lump in the throat, constant eructations, in which the taste of blood was evident to him, and great difficulty in swallowing solids. This, however, he could do by the aid of water, which he kept constantly by his side, and of which he drank after every mouthful he ate. He often expressed himself after drinking, thus:—"There, it's got over!" On the 19th of September, two days after his return from Folkestone, he had a return of the hæmatemesis to an alarming extent. He now began to experience great difficulty in swallowing solids, which appeared to cause a spasmodic effort to reject them. He had an utter loathing and disgust for food. The hæmorrhage again returned in a smaller degree on the 22nd. At this period, by his expressed wish, I passed a probang down to the stomach without difficulty or pain; there was then evidently no narrowing of the œsophagus; and from the absence of blood on the instrument the existence of ulceration was doubtful. He went on without any further loss of blood, though with but little amendment to his general symptoms; but there was a steady increase in the difficulty of swallowing until the 31st of October, when (while preparing to go out) he was again seized with hæmorrhage to a considerable extent, which again yielded to the ordinary remedies in a few days. At this period he vomited almost everything he took as soon as swallowed. He had returns of the hæmorrhage again on the 12th and 17th of November, and on the 28th, after exposure of the body to a current of air, he had slight shivering, followed by bronchitis. Up to this period there had been little or no wasting of the body, and his looks were lively

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and cheerful. He occasionally expectorated small quantities of blood, which appeared, at times, intimately mixed with the bronchial secretion; at other times, large coagula, resembling leeches in size and shape, were expectorated. He began to complain of pain along the margin of the ribs, on the right side, which was relieved by embrocations; after this he frequently expectorated small quantities of blood. He became quite unable to swallow even liquids, which produced an extraordinary combination of coughing and vomiting. Milk, which was his usual beverage, was ejected, mixed with mucus and blood, and I constantly observed that coughing took place on the third mouthful being taken within the lips.

Not being prepared for the condition of parts developed by examination after death, I could not understand why all fluids that were taken into the œsophagus should be immediately returned, undiminished in quantity, and mixed with bronchial exudation.

As he continued to get weaker and to emaciate, the assistance of Dr. Watson was sought, who saw him on the 19th of December. His opinion was that the case was one of malignant disease in the œsophagus, an opinion which had been entertained by Dr. Jeaffreson, who attended the case throughout with me. His dysphagia gradually grew worse; his cough was incessant; and, after great suffering, he died on the 3rd of the present month, as he himself graphically expressed it, "starved to death in the land of plenty." The source of the bleeding becomes a matter of interest, inasmuch as the absence of dysphagia, coupled with the congested state of the liver, renders it probable that in the first attack the hæmorrhage took place from the mucous surface of the stomach, while in the succeeding attacks, the constant taste of blood, which he experienced, with the difficulty and spasmodic character of the efforts of swallowing, point at once to the ulcer as the seat of hæmorrhage.

Post-mortem examination, fifteen hours after death.—The body was greatly emaciated, and the abdomen, which had been pendulous during life, was drawn inwards. Incision shewed the integuments three-quarters of an inch thick with fat, and the muscular substance wasted. The omentum was fatty and without any

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adhesions. The gall-bladder was distended with thick black bile, of the consistence of treacle. The liver, which was small and hard, was in a state of cirrhosis, most advanced along the margin. The stomach and intestines were entirely empty; the former was congested at its larger extremity, but without ulceration. The small intestines were much contracted and reduced in size. The colon was small, except about three inches of the upper end of the ascending portion, where it was distended into a pouch, which was empty. The kidneys and bladder were healthy.

Chest.—The right lung was slightly adherent at its apex, and anteriorly over the upper lobe, the adhesions being recent. It was also found to be adherent to the costal pleura along its posterior half at the base, the adhesion extending obliquely upwards and backwards until it mounted up to the lower margin of the third rib, at a point two inches from the vertebræ, whence it extended to the spinal column. On separating this adhesion it was found to constitute the boundary of a large cavity, containing about three pints of dirty-looking ash-coloured, and very offensive pus. The boundaries of this cavity were, *above*, the lower margin of the third rib; *below*, the costal attachments of the diaphragm; '*internally*,' the spinal column; externally, the pleural adhesion; *in front*, the lung; and *behind*, the ribs; the costal pleura appeared to be absorbed. Along the right side of the posterior mediastinum, and corresponding to the eighth and ninth costo-vertebral articulations, was a small cavity, apparently unconnected with any others, and containing about two ounces of a soft, homogeneous substance, of the consistence of soft butter, and of a darkish-olive colour. Under the microscope it exhibited a granular appearance with a few traces of compound cells. The bronchial tubes were filled with dark, frothy mucus, the result of previous bronchitis. There was no trace of consolidation. The left lung was tolerably healthy, and without adhesions to the ribs. The pericardium was also healthy, and did not contain any fluid. The heart was of the usual size, but the walls of the ventricles were almost entirely composed of fat, very little muscular tissue remaining.

The contents of the chest, with the larynx, trachea and

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œsophagus having been removed, an incision was made along the posterior wall of the œsophagus, the interior of which was healthy down to about five inches from the upper end, at the point corresponding to the bifurcation of the trachea, and just beneath the arch of the aorta; here there existed a rough, ragged ulcer, about two inches in length, extending downwards.

This ulceration extended into the right bronchus, and appeared to have hollowed out a portion of the substance of the lung, producing a cavity as large as a nutmeg. From this cavity it is probable casts of coagulated blood were thrown up during life, sometimes casts of the contiguous bronchial tubes, at other times mixed with mucus.

The aorta was found to be healthy throughout its entire length, and to be untouched by the ulcerative process. The left bronchus was healthy; but a dark spot showed the morbid action to have spread to its exterior. A specimen of the morbid structure has since been examined under the microscope by Dr. Brinton, whose opinion is subjoined.

Mr. PART, *20th of January*, 1857.

Report on this specimen.—The microscope conclusively shews the ulceration to be simple, non-malignant. The portions selected from three different parts of its base, which are, I must confess, to the naked eye, by no means unlike medullary sarcoma in the pulpier free surface, and scirrhus below, are composed exclusively of lung-tissue, and areolar tissue, with vessels. The soft pulp owes its consistence to a quantity of lung epithelium, abnormal in nothing but its amount, and shewing the ordinary lobular tissue in the intervals of its masses. I call such an ulceration "simple" advisedly, the microscope shewing scarcely a trace of inflammatory reaction, either in the shape of lymph, corpuscles, or new fibroid tissue; unless we interpret the lobular infarction of the lungs as reactive, a view, however, which seems unjustifiable.

Hence, taking into consideration the absence of cancerous cell-growth, the presence of the normal differentiation of tissues, and the failure of all evidence of secondary cancerous deposit in

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other organs, there can be no reasonable doubt that the lesion is a simple or non-malignant ulcer.

Dr. Brinton, *17th of February*, 1857.

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13. *Case of Cancer of the Colon, with narrowing of its diameter.*

Mr. B., æt. 52, was a member of the medical profession, and had lost a brother and sister from cancer. He had been obliged to relinquish the active duties of his profession some years since, in consequence of what he described as severe bilious headaches, which confined him to his house for days together, rendering him afraid to encounter the responsibility of any important case. He had the appearance of a man suffering from some severe malady, being thin and wasted, and his complexion dusky. His gait was stooping, as if from pain in the bowels.

About twelve months before his death, which happened on the 3rd of October, he was attacked with pain in the bowels and stomach, and severe vomiting, which yielded to the use of calomel.

I first saw him on the 14th of February last. He was then suffering from severe colic pains of a spasmodic character, which he attributed to having taken some indigestible food. His bowels were constipated, and he felt some nausea, but did not vomit.

A hard tumour, about four inches in length, and two inches and a half in width, was found on the right side of the abdomen, occupying a portion of the right iliac and middle hypogastric regions. This tumour was resonant on percussion, which produced great pain and increased spasm. It was observed that any amount of palpitation or percussion brought back the swelling and pain when it had subsided. Calomel and opium was administered, followed by purgative draughts in the morning; an opiate enema was also given, which afforded temporary relief to his sufferings; but the attack did not entirely pass off until the next day, when the bowels were freely acted upon.

He then took sulphate of zinc in four grain doses, with a view

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of obtaining a regular action on the bowels, the absence of which was always attended with some return of pain.

Under its use the bowels acted regularly, and his health considerably improved, but after a time he discontinued it and had another attack, which was again relieved by calomel and opium, with an opiate enema, followed by others consisting of gruel and turpentine. His attacks recurred at intervals of less duration until the 22nd of September, when he was again seized with the spasm. The remedies which had before been successful were again resorted to, but in this instance without success, and the spasm and swelling, which before had been confined to the ascending colon, were now communicated to the transverse and descending portions of that intestine. Warm fomentations, embrocations, and poultices having failed to give relief, and being unwilling to give more opium on account of the bowels not having acted, tincture of belladonna was added to the enemata. This certainly produced marked relief to the spasm, pain, and swelling, but failed to produce any action on the bowels, and was productive of great and distressing dryness in the throat, complete loss of power in the arms, with great dilatation of the pupils, and some loss of vision.

On the 29th stercoraceous vomiting came on, which much distressed him, as the vomiting usually brought on the pain and spasm. No medicine could be retained. O'Beirne's tube was passed beyond the sigmoid flexure and injections thrown up thereby, but they were returned unaltered. Cold water was thrown up, and was also applied suddenly to the surface of the abdomen without effect.

The abdomen now became tumid, with well-defined transverse elevations, indicating a loaded condition of the small intestines. The vomiting became exceedingly distressing, and he died on the 3rd of October, about a fortnight from the commencement of the attack.

Post-mortem examination, twenty-eight hours after death.—The body was very much emaciated; the chest remarkably small. Both chest and abdomen resonant on percussion.

On laying bare the intestines, they appeared enormously distended, both small intestines and colon. The former were as

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large in calibre as the colon in ordinary cases. They were also thicker to the feel than natural, indicating a greatly hypertrophied condition of both serous and muscular coats.

The omentum was highly vascular, but entirely destitute of fat. It extended down to the pubes. The large intestine on the right side was distended with air, and was translucent, extending considerably over the median line. On the anterior surface, near the ileo-cæcal valve, there was a space the size of a shilling, where the wall of the intestine was exceedingly thin, owing to the peritoneal coat having given way. Over this spot, the omentum had contracted some adhesions, as if to repair the injury caused by the distention; this having been the seat of the tumour during his attacks.

At the hepatic curvature of the intestines, at the point where it crossed the duodenum and right kidney, the intestine suddenly became narrowed, so as barely to admit the point of the little finger; it was also bound down to the parts beneath by adhesions.

The stomach and small intestines as well as the ascending colon, were filled with brown semi-fluid matter, having a powerful stercoraceous odour. The mucous lining of the stomach, and small intestines were healthy, while the muscular coat of the whole alimentary tube, from the stomach to the commencement of the ascending colon, was enormously hypertrophied.

The ileo-cæcal valve was obliterated by the distended condition of the parts about; the whole lining of the ascending colon was much injected, and at its hepatic curvature above indicated, the calibre of the intestine was narrowed, to about the size of a large catheter. For about an inch in length, its walls were hard and thickened, and the mucous membrane, was the seat of cancerous ulceration, in its entire circumference. At one point, the wall of the bowel had just given way, and there was a round hole, large enough to admit the passage of a crow-quill. Beyond this point, the transverse and descending colon, which were found empty, were pale and healthy, and the walls little, if at all, thickened. The kidneys and bladder were healthy. The chest and head were not permitted to be examined.

Mr. Part, *20th of January*, 1857.

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14. *Portion of Small Intestine Passed per Anum after Symptoms of Intestinal Obstruction.*

This specimen was sent by Mr. Ward, Surgeon, of Bodmin, in whose practice the case occurred, to Mr. Way, the House Surgeon to King's College Hospital, by whom it was transferred for the purpose of exhibition.

The patient was a female, æt. 23, married, who, six months ago, became subject to severe pains in the loins and abdomen, followed by symptoms of strangury. The disease had been mistaken for uterine cancer. When Mr. Ward saw her, she had been ill three months, and was then much emaciated; pulse one hundred and twenty, scarcely to be felt, and occasionally intermittent. Tongue dry and furred. Bowels apt to be, but not completely, constipated, with frequent and painful micturition; urine of low specific gravity, slightly albuminous, and containing considerable lithates. Frequent vomiting of matters existed, not distinctly fæcal, but consisting apparently of partly digested food, and coming on about an hour after eating. Much griping pain in the bowels. Catamenia suppressed. Some pain on pressure over the right kidney region. No uterine disease was apparent, per vaginam. In November last the patient voided by stool the produced portion of small intestine.

It is about eight inches long, by one inch and a half in diameter, and consists apparently, of some of the upper portion of the ileum, and of the lower end of the jejunum. It is separated from the mesentery close to the tube. One end is squarely divided, and the other rather frayed off. A few faint valvulæ conniventes are seen on the mucous membrane.

For a month afterwards, the patient went on pretty well, but since then she has had a return of the symptoms of intestinal strangulation, has constant vomiting, and passes nothing more than a scanty fluid per anum.

Mr. John Wood, *20th of January*, 1857.

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15. *Fatal Intestinal Obstruction produced by Adhesions External to the Gut.*

E. M., a greengrocer, æt. 40, was in St. Thomas's Hospital, under my care, for three weeks. He had been taken ill seven weeks before admission, so that the entire duration of his malady was about ten weeks. He was attacked, in the first instance, suddenly, with severe colicky pains, which bent him double, and confined him to his bed for two or three days. At the end of this time, feeling somewhat improved, he returned to his work; but in a few days his illness recurred with the same symptoms, and he was again obliged to take to his bed. For three weeks the pains continued constant, but subject to severe exacerbations; and during this time, he suffered from loss of appetite, nausea and occasional vomiting, and constipation without actual stoppage. He improved a second time; and for about ten days remained free from pain, and was apparently convalescent, though the bowels were still unusually costive. Ten days before his admission the symptoms came on again very violently; the pain reappeared, of the same character, but more severe; the sickness became more constant; he vomited an hour or two after everything he took, and his bowels were unopened, though strong purgatives were administered, both by mouth and per anum.

On admission, he appeared to be emaciated, and looked anxious. He lay on his back, finding that the easiest posture. His pulse was eighty-four; his tongue clean, though feeling clammy to him. He was thirsty, had no appetite, and vomited regularly two or three hours after taking any food. The skin was warm and dryish. The belly was distended, tight, and tympanitic, and decidedly tender on pressure. He complained of constant pain in it; but severe exacerbations, lasting two or three minutes, would come on at irregular intervals—on the average about every five minutes. During these exacerbations, a gurgling sound was usually to be heard; and he stated that it seemed always to begin somewhere on the left side, and to cease at a definite point on the right. He was treated at first with mercury, anodynes, leeches, and warm baths; and for a few days there appeared to be a little improvement, though the bowels were still unacted upon, and the

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vomiting and pain were not wholly subdued. On the fourth day after admission, a copious injection of warm water was administered, and some hours afterwards it returned, with a considerable admixture of fæcal matter. It was repeated the next day, with a similar result; but after its employment on this occasion, he vomited a large quantity of pea-soup-like stercoraceous matter. As the injections appeared to relieve him somewhat, they were continued daily; but the amount of fæcal matter they brought away, gradually diminished, and at length almost ceased. The stercoraceous vomiting, from the time of its first appearance, never left him, but recurred two or three times a day up to his death. He gradually became exceedingly feeble and emaciated. The abdomen became distended, and the inflated coils of intestines remarkably distinct; and when the paroxysms of pain came on, as they continued to do every five or ten minutes, the progress of the peristaltic action could be followed with the greatest facility.

He still lay chiefly on his back, and his belly continued tender to pressure, though not acutely so. He was very thirsty, and had no appetite, though he felt no nausea, except immediately prior to his attacks of vomiting. His tongue was clean, his skin warm, his pulse from one hundred to one hundred and twelve, and weak. He was never troubled with hiccough. For the last week of his life, we endeavoured to support his life by beef-tea injections, and to relieve his paroxysms of pain by morphia. He gradually sunk, however, and died on the twentieth day after his admission.

Autopsy.—The body was extremely emaciated; but the abdomen was much distended, and the coils of intestine were as distinct as during life. The thoracic viscera were healthy. On opening the abdomen, the small intestines were found to be, for the most part, enormously distended; the colour of their surface was generally heightened, and bands of rather intense capillary congestion extended irregularly along them. There was no appearance of recent lymph, and no collection of fluid in the peritoneal cavity. On tracing the small intestines from the duodenum downwards, they were found to be in the condition described above, until they reached the middle of the

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ileum; from which point to within a foot of the cæcum, they were adherent to one another and to the brim of the pelvis by means of bands and filaments of false membrane. This false membrane had the usual character of cellular tissue, was much congested, and could be torn through with some degree of facility. The portions of intestine, which were adherent, were so entangled that their direction was traced with considerable difficulty. It did not appear, however, that there was anything to account for this, beyond the adhesion arising from a local peritonitis—there was nothing of the nature of a hernia—nothing in the shape of an intus-susception. The portion of intestine involved was, for the most part, somewhat dilated; the lowest part, however, was contracted, and the part that intervened between it and the cæcum was firmly contracted and empty, and not larger than the tip of the little finger. The stomach and small intestines, down to the seat of disease, were loaded with thin pea-soup-like fluid, and some of this occupied the upper two-thirds of the portion of adherent intestine; but the remaining third, and the portion between it and the cæcum were empty. There was no complete stricture—no part of the intestine through which the finger could not readily be passed; so that the obstruction which had existed during life was evidently due to the embarrassment in the action of the bowels, and the compression, which had resulted from the gradual contraction of adhesions formed, probably, at no remote period. The cæcum and large intestine were contracted throughout; but here and there in the ascending colon were small lumps of hardened fæces. The mucous membrane of the alimentary canal was everywhere healthy. Liver, spleen, pancreas, kidneys, and supra-renal capsules, healthy.

The above case presents several points of interest. In the first place, fatal obstruction to the passage of fæces was produced, although the intestines were still pervious, by the embarrassment which resulted from the contraction of adhesions external to them. In the second place, it is clear that the adhesions found to exist must have resulted from peritoneal inflammation, a disease which could scarcely have existed without marked symptoms; and as he appears to have enjoyed invariable good health up to the commencement of the illness of which he died, and as the

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symptoms of which he complained in the first instance, were not unlike those of partial and perhaps not very severe peritonitis, I am inclined to believe that the pouring out of the lymph which formed the adhesions, took place only ten weeks before his death. This view is favoured by the consideration that, had the adhesions existed for any length of time, they could scarcely have failed to have been productive of serious inconvenience, and yet, prior to the illness of which he died, he does not appear to have laboured under any symptoms of abdominal affection.

Dr. Bristowe, *3rd of February*, 1857.

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16. *Perforation of Intestine. Typhoid Fever.*

This case was brought under notice of the Society for several reasons.

1. It was a case of typhoid fever in which the symptoms were so slightly marked, that few, I suspect, from the symptoms anterior to perforation would have ventured to diagnose what the necropsy revealed. Still, as is well known, cases of this kind are common, and there is no doubt that many a slight febrile attack, and many a mild diarrhœa, are really examples of this disease.

2. The fever appeared to have been produced, not by contagion, not apparently by bad or insufficient food, by bad drainage, or by want of ventilation; but by exposure to cold and wet. Exposure to the inclemency of the weather, I believe, not infrequently produces this affection; and I have in my recollection one of the most severe and characteristic cases of typhoid fever I ever saw, and one, the diagnosis of which was verified by *post-mortem* examination, in which there was very little doubt that the disease was brought on by the hardships which attended shipwreck.

3. It afforded an example of perforation of the intestines, in a case in which the symptoms of the disease were slight, and in which the ulcers were few and small. This, however, is usual; and it would seem that perforation is determined, not so much by the amount of ulceration, as by accidental causes producing laceration—causes which are far more likely to arise in indi-

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viduals who appear but slightly indisposed, and in whom, probably, the ulceration is of small amount, than in those who are utterly prostrated by the severity of the disease, and in whom, therefore, the ulcers are probably large and numerous.

4. But the most interesting point about the case is the fact, that the perforation did not, as usual, cause death in a day or two, but that it took place a fortnight before the patient died. A portion of the contents of the bowel appears to have oozed through the opening into the peritoneal cavity, and then by the inflammation it excited to have been confined by adhesions to a small segment only of that cavity—in other words to have become encysted. It is not uncommon to find that irritating matters, which have escaped into the abdominal cavity, have become encysted in a similar way, and that the fatal issue, which would otherwise have been almost immediate, has thus been delayed (see pp. 344 and 346, vol. iii. "Path. Trans."); but the accompanying case is the only one which I have met with, in which such an event has occurred in connection with typhoid fever.

History of the Case.—S. W., a sailor, æt. 15, was admitted into St. Thomas's Hospital, under my care, on the 1st of January, 1857. He stated that he had always enjoyed good health; that about the 18th of December, while at sea, he was taken rather poorly with pains in the thighs, and that these pains continued until Christmas day. His appetite was very good, his bowels regular, and, indeed, except for the pains in his thighs, he seems to have complained of nothing. Before, and during this time, he was much exposed to wet and cold, to which causes he attributed his illness. On Christmas day he was attacked with severe pain in the belly, which has continued up to the present time. It came on in paroxysms which were very severe, but not of a griping character. It was increased by coughing. He became thirsty; his appetite disappeared; but he did not suffer from nausea. The bowels have only been opened twice, slightly, during the week. He has been on board ship all the time, generally in bed, but sometimes sitting by the fire.

At the time of his admission, the following notes were taken:—"His face is flushed, his skin hot and somewhat dry, and there is no trace of rash; pulse ninety-two. He is thirsty, without appetite,

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and has a thin fur upon his tongue; has no nausea, no headache and no pain in his limbs. He is perfectly sensible and rational, and it does not appear that his mind has the slightest tendency to wander. He lies on his side with his knees drawn up, finding that the easiest position. He suffers pain in his belly when he lies on his back, and especially when he sits up and leans forward, or when he draws a deep breath: but he feels no uneasiness in passing his water or motions. The belly is not swelled, but its parietes are firm. He complains of much pain on pressure, even when it is evenly applied. It is greatest above the navel, but no part is free. As he lies in bed he often feels scarcely any pain, but he is subject to very severe paroxysms which come on frequently, but irregularly. During these, groans are forced from him, and he evidently suffers intensely; but he does not press his belly, or rub it, having proved by experience that that only increases the pain. His respirations are shallow and about thirty-six in a minute."

The patient was treated for peritonitis, and during the next three or four days appeared to be improving, that is to say, the pain diminished and he was able to lie in any position, and expressed himself much better; still in other respects he did not improve and the belly became somewhat tympanitic, and the pulse more rapid.

On the 7th, the following notes were taken:—"During the last two days he has become decidedly worse, the belly has become distended and tympanitic, and it is again becoming tender to pressure, especially in the flanks. His bowels have been freely opened to day and yesterday, and he is sick after everything he takes. He is not very thirsty, but his tongue is covered with a whitey-brown fur. Has no headache. Skin warm, not moist. He has become thinner; is dark and sunk under the eyes, and looks very anxious." After these notes were taken the patient became much worse, passed a restless night, vomited constantly, and died at half past eleven A.M. on the 9th.

Post-mortem examination.—The thoracic viscera were perfectly healthy, except that there was a recent deposit of lymph on the base of the right lung, and on the portion of diaphragm in contact with it. On opening the peritoneal cavity, a considerable quantity of milky fluid escaped, which appeared to have occupied chiefly the

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pelvis and the left lumbar region. Almost the whole of the peritoneal surface was covered by a thickish, soft, opaque, white layer of lymph. The great omentum was invested in a quantity of this deposit, and adhered to the abdominal parietes on the one hand, and to the small intestines on the other. The small intestines were collected into a mass, which was surrounded by a similar layer; and on tearing this through, they were found slightly attached to one another by an exceedingly thin film of lymph. The pelvic organs and stomach also were surrounded by fibrinous deposit. The upper part of the left lobe of the liver was in contact with the diaphragm, but not adherent to it, and looked healthy. The left and anterior half of the upper surface of the right lobe was covered by whitish recent lymph, and was separated from the right and posterior half by a very irregular and sinuous line of adhesions. On endeavouring to remove this organ, a cavity was exposed which occupied the upper part of the right lumbar region, and extended between the liver and diaphragm. It contained thick, yellowish, and somewhat offensive puriform fluid, and was lined by a thick layer of lymph, which presented a dirty-yellow hue. The parietes were formed partly by the liver, partly by the diaphragm, partly by the mass of small intestines (including portions of the lower half of the ileum) partly by the upper half of the ascending and commencement of the transverse colon, and partly also by the upper half of the right kidney. On examining that part of the parietes formed by the small intestines, a small perforation was detected, through which fæces and air escaped when the intestines were pressed. That portion of the liver involved presented an exceedingly abrupt and elevated, but irregular, margin, which was surrounded by a broad rim of congestion.

Excepting the congestion which existed in the neighbourhood of the abscess, the liver appeared to be perfectly healthy. The spleen was surrounded by a layer of pale soft lymph, but was healthy. Pancreas, kidneys, and supra-renal capsules healthy; stomach, large intestines, and greater part of small intestines healthy also. Several of Peyer's patches in the lower part of the ileum were of a dark colour, apparently from congestion; and here and there, both in them and in the solitary glands were

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ulcers, which varied from the size of a split pea downwards. Most of them were shallow and round or oval in outline. Several, however, were somewhat deep, and to one or two of them a yellow slough was still adherent. Two or three of the largest and deepest ulcers were situated at about a foot and a half from the cæcum, and in one of them a perforation, large enough to admit a No. 4 catheter, existed. On looking to the peritoneal surface, this was found to correspond to a patch of that lymph which had formed the boundary of the cavity before described.

Some of the mesenteric glands were enlarged, soft and vascular.

From the *post-mortem* appearances there can be no doubt that the above was a case of mild typhoid fever; and from the history it seems pretty certain that the patient was labouring under the disease at the time he complained of pain in his thighs, and that that indeed was to him, the most serious of a set of mild symptoms, which constituted a slight febrile attack. It is equally clear, I think, that the perforation of the intestine occurred at that time (a week before admission) when he was attacked with sudden abdominal pain, and from which the symptoms of peritonitis dated.

Dr. Bristowe, *3rd of February*, 1857.

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17. *Cancer of the Stomach undergoing a Cure.*

M. F., æt. 65, was admitted under Dr. Gull's care in Guy's Hospital, on the 6th of August, and died the 24th of November, 1856. For about a year before admission, this man had been suffering from vomiting of food, and other gastric symptoms, accompanied by great emaciation, indicative of an obstruction at the pylorus. He was so wasted and feeble, that he was obliged to be placed in bed; and he appeared as if he could not survive many days. He had been so long in the habit of rejecting his food, that he now took very little. In the course of a few days, however, he was enabled to eat something more, and this in part remained down; and at the expiration of three or four weeks, he had passed several days without vomiting. After this time, he generally retained on his stomach the small quantity of food

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which he swallowed, and only on exceptional occasions did he again vomit it; the pyloric tumour also became less distinct, so that fresh visitors to the case were unable to detect it. He continued thus much in the same state during four months, not indeed improving in health, although not retrograding, and the gastric symptoms became much less severe. He appeared to be no worse immediately before his death.

Upon *post-mortem* examination, a layer of recent lymph was found on the right lung, so that pleurisy had been the cause of death. The stomach was in its natural position, and about the ordinary size. Some large tumours or glands were seen at the lesser curvature, and the pylorus was felt to be hard, and rather increased in size. This was owing to the surrounding structures being adherent to it, and the peritoneum being thickened and puckered. All the other organs were healthy, so that when the stomach was taken out, the whole of the disease was removed. On opening this organ, the little finger could be easily passed through the pylorus; and on examining the walls of the latter, they were found to be rather thinner than natural; and instead of having the natural soft and elastic feel, they were hard, tough, and parchment-like. The coats were blended together, and their healthy structure in great part destroyed. Amongst them was seen a yellowish-white deposit, which was found, by the microscope, to consist of irregularly-shaped cells, and fatty granules, and was in all probability dead cancer. At the lesser curvature, were some enlarged glands, about the size of chestnuts. These upon section, were found to consist of a semi-fluid curdy material, composed principally of fatty granules, such as is seen in decayed inflammatory exudations, but especially in cancer which has lost its vitality. In one gland there existed some true encephaloid matter around its circumference, emitting a milky juice on pressure, and exhibiting large nucleated cells beneath the microscope. In the midst of this gland, however, was some of the soft, yellowish, decaying material, sending radiating streaks throughout, towards the surface, so that it was tolerably clear that in a very short time longer, even this remnant of cancer would have been destroyed; and then the question would have arisen as to the nature of the gastric disease, from which this man had suffered.

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It appeared then tolerably certain that here was an instance of a man who had been attacked with carcinomatous disease of the pylorus, together with a similar affection of the neighbouring lymphatic glands, and that the case had run its usual course in the usual period, but that owing to new circumstances coming into operation, the malady was arrested, no fresh carcinomatous growths appearing, and those already existing beginning to decay. As a consequence, the pyloric tumour became less evident, the gastric symptoms less urgent, and the man, instead of dying in a few days, as was expected, survived four months. It would be impossible to say whether the cancerous diathesis of this patient was changed for a better one, or whether the disease was merely checked in common with all other operations of the body, from the mere exhaustion of the powers of the system; but even should the latter be the simple explanation, it proves that cancer may be starved out. This has already received some confirmation from those cases where the disease has been local and external, and has remained in a stationary condition for a great many years.

Dr. Wilks, *3rd of February*, 1857.

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18. *Case of Perforating Ulcer of the Stomach.*

Near the pylorus, inferiorly, was an ulcerated surface about the size of a half-crown piece, irregularly shaped, and apparently cicatrized. Within the area of this was a smooth, circular, perforating ulcer, with abrupt internal edge, as it were, "clean cut," bevelled, half an inch diameter internally. No cancerous deposit around.

The subject of it was a man, æt. 54, of spare habit of body. He was seized suddenly with very severe pain at a spot two to three inches above the umbilicus, soon followed by pain over the whole abdomen, and collapse. He died sixteen hours after the seizure.

For two or three years previously he had had tenderness at the epigastrium on pressure, and a sense of discomfort and fulness if he made a hearty meal. Seven months before death he had hæmatemesis and vomited half a pint of blood in one day; but had no return of this hæmorrhage, and to the day of his

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death he was apparently in good health,—he did not lose flesh or strength.

Mr. T. Robinson, *17th of February*, 1857.

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19. *Cancer of the Œsophagus fatal by Hæmorrhage from one of the Intercostal Arteries.*

The following case of hæmorrhage from the œsophagus is interesting, from the fact that the loss of blood took place from one of the intercostal arteries, which had been laid open by the extension of a cancerous ulcer. Hæmorrhage from this source, in malignant disease of the œsophagus, must undoubtedly be very rare; and yet, from the close proximity of the intercostal vessels to the seat of disease, it is surprising that such an accident does not more frequently produce the fatal event.

The person, from whom the preparation was taken, was a married woman, æt. 37, who was admitted into St. Thomas's Hospital on the 20th of January, 1857. About a year before her admission, having up to that time enjoyed good health, she began to feel a soreness, after swallowing hard food, in the mid-sternal region. This symptom, with occasional vomiting, but with little impairment of her general health, continued during nine months. About three months ago soreness and pain became constant, though much aggravated during deglutition. An actual difficulty also of swallowing came on, the food returning after having apparently reached a certain point in the course of the œsophagus. About a month ago, she passed slime and blood from the bowels during a whole week, since which she has rapidly lost flesh. She has never vomited blood. When admitted she was very thin, pale, and sallow, and complained of great debility. Her appetite was bad, her tongue furred, and her pulse quick and feeble. No tumour could be detected in the throat. She swallowed with pain and difficulty.

On the 27th, all the symptoms having become more alarming, a bougie was passed down the œsophagus, by means of which a constriction was found to exist at about the junction of its middle and lower thirds. A piece of sloughy-tissue, which adhered to the end of the instrument, examined under the

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microscope was found to present a large quantity of epithelium.

She gradully became weaker, and on the 6th of February suddenly vomited about a pint of blood. After this she sunk into a state of collapse, her breathing became hurried and laborious, her countenance pinched and anxious, and her pulse one hundred and twenty, and very weak. Tannic acid in five-grain doses was ordered three times a day. She continued in the same state throughout the whole of the 7th; but on the morning of the 8th appeared to rally somewhat; she sank and died, however, somewhat suddenly at one o'clock P. M.

Autopsy.—The body was anæmic and spare.

The left pleural sac was healthy; the right was obliterated by old adhesions. The lungs were pale but crepitant, and healthy-looking throughout. The pericardium and heart were perfectly healthy; the latter was firmly contracted, and its ventricles were empty. The structures occupying the neck and the posterior mediastinum were removed together. On laying open the œsophagus, the lower partof its middle third—about three inches of its length—was found to be the seat of malignant disease. The tissues involved were indurated, and presented, for the most part, the character of scirrhus. They varied from half an inch in thickness downwards. The outer surface of this hard growth was moulded upon the descending arch of the aorta and corresponding portion of the vertebral column, without however, involving either. The internal surface was irregularly excavated, and presented around its margins, and here and there upon its surface, nodulated masses of soft encephaloid substance, some of which were in a sloughy condition. A little altered blood adhered to various parts of the surface. The second intercostal artery springing from the aorta on the right side, at a quarter of an inch from its origin, opened directly into the ulcer; and it was perfectly clear that the fatal hæmorrhage had taken place from this vessel. The mucous membrane of the œsophagus appeared to be healthy up to the very margin of the ulcer; that below presented some enlarged follicles, and the corresponding part of the tube contained a little, black, sticky, altered blood.

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The peritoneum was healthy. The stomach was healthy, but large, and contained a solid reddish-brown coagulum, which was moulded to its shape, and weighed eighteen ounces. The small intestines, from one end to the other, contained blood, of which that in the ileum was almost black. The cæcum, ascending and transverse colon, were distended with an accumulation of black, pitchy, blood; and the rest of the large intestines, though contracted, contained a little similar material. The uterus and ovaries were healthy. The liver, spleen, and kidneys were also healthy, but very pale.

Under the microscope, the cancerous growth presented a quantity of fibroid tissue, vessels loaded with more or less altered blood, and nucleated cells of various forms. It did not appear to belong to the epithelial variety of cancer.

Dr. Bristowe, *17th of February*, 1857.

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20. *Large Albuminous Concretion found loose within the Cavity of the Abdomen.*

The specimen was removed from a dissecting-room subject, by the late Professor John Reid, several years ago. It is somewhat larger than a billiard-ball, and was found loose within the cavity of the peritoneum, at the upper part of the pelvis. With the exception of a few depressions on its surface, it is perfectly round and smooth. On making a section of it, it was found to consist of a nucleus, partially calcareous, and of a number of concentric laminæ, which were very elastic. The man, from whose body the mass was taken, had been under the care of Dr. Smith, in the City Charity Workhouse, and had never complained of any uneasiness in the abdomen.*

This specimen Dr. Bennett had considered unique, until he saw another very similar to it, described and figured in the Pathological Society's "Transactions," (vol. vi. p. 205,) by Mr. Shaw. The two specimens, with the exception of size, closely resemble one another. Mr. Shaw states the nucleus of his specimen to be composed of adipose tissue, with a fibrous envelope, infiltrated with mineral matter. A section of the

* "Edinb. Med. and Surg. Journal," vol. xlvi. p. 61.

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nucleus, of Dr. Bennett's specimen, presents a remarkable appearance under the microscope. It consists essentially of the segments of large cells, very probably those of fat, separated by slightly fibrous partitions, in which traces of fusiform bodies are faintly visible. Towards the periphery of the nucleus the cells are filled with mineral matter, which, in a molecular form, is infiltrated through, and gives firmness to the external portion of the nucleus, which is surrounded also by a fibro-calcareous envelope. Plate IV., Fig. 2.

This and Mr. Shaw's specimen, belong to a class of concretions, which Dr. Bennett calls albuminous concretions, resulting from the mechanical deposition of coagulated albumen. The concentric layers of aneurismal coagula, and some of the so-called fibroid deposits on the valves of the heart are of the same character. Though formed of organizable matter, they are not organized, being simply the result of chemical precipitations going on in the living body. In this respect they resemble fatty, pigmentary, mineral, and other concretions.

It has been supposed that they may arise as the result of growth from the uterus, intestinal walls, or sigmoid valves; and the specimen forwarded possesses a round depression in one spot, which was unfortunately removed in order to obtain a flat surface for the microscopic section, but it may still be seen on the edge of the detached piece. Dr. Bennett is more inclined to adopt the view of Mr. Shaw, in consequence of the regularity of the concentric laminæ completely round the nucleus, causing it to resemble the successive mineral deposits round a centre, so common in urinary calculi. The coagulating action of fat on albumen was first shown by Acherson, and readily explains how one of the *appendices epiploicæ*, should it become loose, would be immediately coated with albuminous matter. Subsequently successive layers of albumen would collect upon it, and cause its enlargement. The living appendices, it is true, do not produce these concretions, but we have every reason to believe that all dead, floating organic matters, especially if fatty, do, as has been recently observed in the "Lithopædium," so well described by Geuns and Schrant, of Amsterdam.* The mineral degeneration of

* "Over Bailenbaarmoederligke Zwangerschap."—*Amsterdam*, 1855.

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the nucleus, however, appears to be more probably the result of a subsequent metamorphosis of the constituents of the concretion.

Dr. QUAIN for Dr. HUGHES BENNETT, *17th of February*, 1857.

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21. *Specimens of Loose Bodies found in the Peritoneal Cavity.*

In a dissecting-room subject in Guy's Hospital, was found a loose body in the abdomen resembling those which have before been exhibited to the Society. It was in contact with the small intestine, and was on the left side of the body. It consisted of a hard substance, about the size and shape of a bean, having a rounded surface, and to one side was attached a filament of cellular tissue, about half an inch in length, whose other end was free. On making a section of it, the exterior was found to be composed of a firm, tough, and fibrous coat which surrounded the body, and was not above the one-twentieth of an inch in thickness.

The interior was composed of a soft yellow matter, crossed by harder whitish bands connected with the capsule. Under the microscope the exterior presented the ordinary appearance of areolar tissue, but was difficult to tear. The interior consisted, also, of bands of areolar fibres, containing distinct vessels, and surrounded by evident fat cells; besides these there were shreds of membranes covered with granules, which became more distinct after the fat was removed by ether.

At the time this loose body was found, another was discovered also in a dissecting-room subject, which exactly corresponded to it, but was developed within one of the appendices epiploicæ. It was a hard oval body, rather smaller than the one just described, being about the size of a large pea, and presenting a slight depression in the centre; it was connected to the intestine by a pedicle of peritoneum, which formed part of the attachment of an appendix epiploica, so that the tumour seemed to grow from the side of this structure. On making a section there was first, a firm fibrous coat; secondly, a continuous earthy coat, cutting like bone, and, thirdly, a yellowish, powdery interior, part of which fell out on making a section, and the remainder appeared gritty. On more minute examination the external fibrous coat appeared to consist of layers of membrane difficult to

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DESCRIPTION OF PLATE IV.

Figures 1 and 2 illustrate the Structure of the Nucleus in Dr. Hughes Bennett's case of Albuminous Concretion from the Abdominal Cavity, p. 212.

Fig. 1. Section of the nucleus of the natural size.

Fig. 2. Portion of the same section, magnified 50 diameters.

Figures 3 to 5 illustrate Mr. Amos Beardsley's case of Gastric Polypus, p. 219.

Fig. 3. The tumour, of the natural size.

Fig. 4. The same, divided by an incision through nearly its whole length.

Fig. 5. Microscopic structure of the same.

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Fig 2

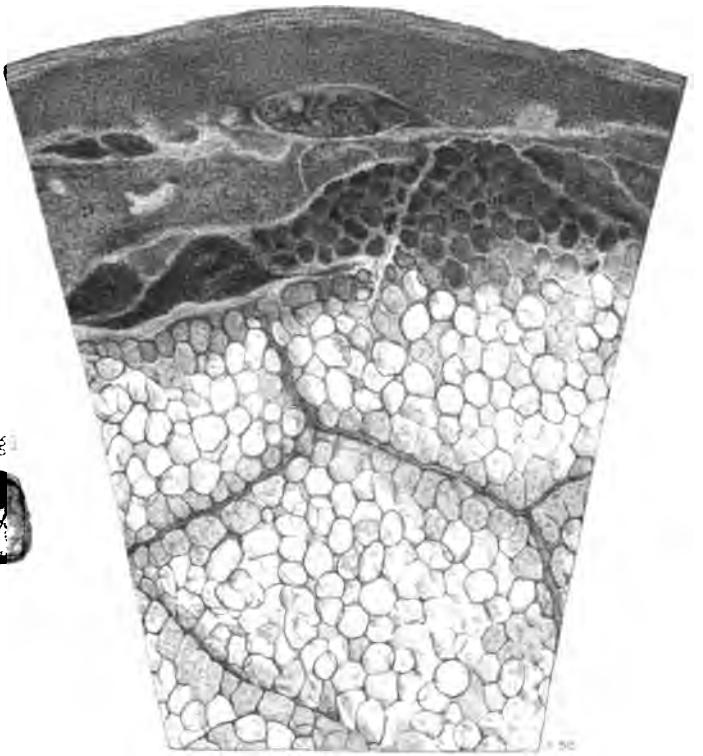

Fig 1

Fig 3

Fig 5

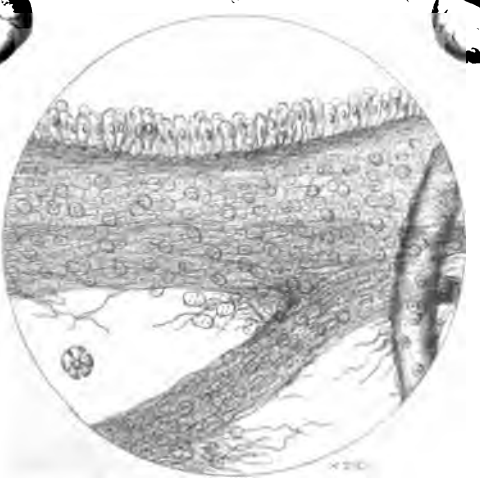

Fig 4

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separate, and which, under the microscope, presented the appearance of membrane covered with granules (insoluble in ether or acetic acid) whose edges were extended into filamentous processes, the membrane itself presenting very indistinct traces of fibrillation. The next tunic was hard and earthy. A thin section being made, it appeared structureless, but had minute canals ramifying through it. Acetic acid had no effect on this, but concentrated hydrochloric acid caused effervescence, and left a pellucid structureless membrane. The internal powdery matter was composed of fat granules, (not in cells) and granular membrane with a quantity of crystalline matter of indefinite shape, soluble with effervescence in hydrochloric acid.

These bodies resembled, in appearance and structure, each other, and also certain preparations in Guy's Hospital Museum; likewise they were very similar to preparations already exhibited to the Society, and particularly to one, shewn by Mr. Shaw, who considered it to be an appendix epiploica which had dropped off and subsequently become covered with fibrinous membrane. This supposition would appear to be borne out by the present specimens, and by two preparations in Guy's Hospital Museum, the one shewing a bifurcated appendix twisted on its pedicle so as to appear strangulated, the body appearing not much changed, and another shewing a further stage, in which there is attached to the intestine by a mere filament, an oval substance resembling the present specimen, and exactly in the position that if the thread were to break, the body would be set free.

It appears, then, that these bodies are developed in, and do not form the whole of an appendix epiploica, and that in this, as in other specimens, the surface is rounded and does not present the appearance of the strangulated appendix before alluded to, but that it has acquired all the structures described while in continuity with the intestine, and with a broad pedicle; in fact, the earthy coat and degenerated interior are more distinct in the second than the first specimen. I am, therefore, led to suppose that these are growths formed in the appendices epiploicæ, which are subsequently set free by the strangulation of the pedicle, and I am inclined to suppose that they may be alterations of

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lymphatic glands, which I have found to exist in some appendices epiploicæ.

Dr. Wilks for Dr. Brown, 17*th of February*, 1857.

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22. *Loose Body found in the Abdominal Cavity.*

This body was discovered in a female subject, lying loosely in the cavity of the pelvis. It was almond-shaped, about half an inch long, and at its smaller extremity presented a minute projection, probably the remains of a pedicle, by which it was at one time fixed. The external surface was smooth and shining; on section it was found to consist of a firm semi-cartilaginous capsule, enclosing a yellow pulpy material, which contained numerous gritty particles. On *microscopic examination*, these contents were found to consist of fatty granules, and some irregular, hard, mineral masses, requiring hydrochloric acid for their solution.

On examining the colon in this subject, one of the appendices epiploicæ, attached to the sigmoid flexure, was found much altered in structure, resembling, in fact, the body just described, and it was attached by a very small pedicle, so slender indeed, that a very gentle force might have detached it. There can, therefore, be little doubt, but that the loose body just described had resulted from a degeneration of one of the appendices epiploicæ, and its subsequent separation.

Dr. Van der Byl, 21*st of April*, 1857.

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23. *Specimens Illustrating the Formation of Loose Bodies in the Abdominal Cavity.*

These specimens were found in a male subject, and consisted of two of the appendices epiploicæ attached to the transverse colon. They were both much altered in structure, about three quarters of an inch long, slightly flattened, and furnished with very slender pedicles. One is very firm, and presents a semi-cartilaginous consistence, the other is dark coloured, and appears to contain blood.

It is quite possible, that owing to the constriction of the pedicle, a vessel had burst, and this accident may have aided the

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degeneration of the fatty appendix. In vol. vi. p. 211, of the "Pathological Society's Transactions," Dr. Van der Byl. has described a loose body found in the peritoneal cavity, which he believes was formed in the manner he has endeavoured to illustrate. In connexion with this subject, the author alluded to the loose body removed from a hernial sac by Mr. Shaw, and stated that in the *Lancet* for 1850, vol. i. p. 187; there is described a large concretion, lying loosely in a hernial sac, which was exhibited at the Westminster Medical Society, by Mr. Canton, and which exactly resembled that exhibited by Mr. Shaw.* Dr. Van der Byl, 21*st of April*, 1857.

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24. *Gelatiniform Degeneration of the Right Half of the Stomach, and of the Intestines.*

The disease followed upon extirpation of the supra-renal capsules. The animal, a white rat, had the right capsule extirpated on the 5th of February. Nine days afterwards, it appeared quite well; and the left capsule was removed. The colour of the hair and of the skin was carefully watched, without any peculiarity being observed until the 23rd or 24th of February, when the neck of the animal was noticed to have become denuded of hair. The skin, however, retained its white colour. The animal from this time began to refuse to take food, and gradually to get weaker and weaker until it died, on the 2nd of March—twenty-five days after the extirpation of the right, and sixteen after the removal of the left supra-renal capsule. No discolorization of the skin could be detected. The portion of skin that had been denuded of hair, was now seen to be covered with a luxuriant crop of young hair, about one-eighth of an inch long; shewing that the affection of the appendages of the skin had not been permanent, but only transient.

* "Trans. Path. Soc." vol. vi. p. 204. In the same vol. p. 208, Dr. John Ogle has described a loose body found in the peritoneal cavity which had been contained in a depression in the upper surface of the liver, of exactly corresponding size, and lined by the fibrous covering of the organ, at the margin of which depression was a small pedicle, with which the loose body had evidently been connected. Unlike the present cases this one just quoted had evidently *not* been formed by one of the fatty appendices of the intestine.—Ed.

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On opening the abdomen, the intestines looked like a gelatinous mass, and were so thin and transparent, that the air bubbles could be distinctly seen floating in their interior. The right half of the stomach was in a similar condition, and contained only a clear amber-coloured mucus, with a faintly alkaline reaction. On the left side, the wound in the peritoneum could only be detected on the closest inspection, while on the right side, the liver was found attached, by somewhat strong adhesions, to the wound. The disease was probably produced by the injury done to the ganglionic system of nerves in removing the capsules; and the right side of the stomach being most affected, could be accounted for by the greater injury done to the nerves. On this side, the operation was performed with difficulty, in consequence of the capsule adhering to the inferior vena cava.

Dr. Harley, *3rd of March*, 1857.

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25. *Large Cyst in the Coats of the Stomach.*

This specimen shewed a cystic tumour in the coats of the stomach, close to the pyloric orifice. It was of about the size and shape of a walnut, and projected both externally beneath the peritoneum, and internally beneath the mucous membrane, having perforated the muscular coat. It thus possessed a shape approaching that of an hour-glass. Internally its size was sufficient to completely occlude, as a valve, the pyloric opening; but, by pressure, the fluid might be emptied into the subperitoneal half of the cyst, when the mucous membrane would hang loose. With the finger, the constricted orifice of communication between the two halves of the cyst might easily be felt. There were no signs of inflammation about the cyst, nor were either its mucous or serous investments at all thickened. The preparation was in the first instance shewn to the Society, the cyst being unopened, in order that the valve-like occlusion of the pyloric canal might be demonstrated. The cyst was afterwards opened, and found to contain about half an ounce of a thick, opaque, pinkish fluid, glittering with plates of cholestearine. Nothing at all resembling the remains of an hydatid was discovered.

The history of the case went to shew, that the cyst in the

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stomach had occasioned no symptoms, and had not, in any way, been connected with the cause of death. The stomach had been removed by Dr. Sloane, the resident medical officer to the Leicester Infirmary, from the body of a man, æt. 33, who had died of fever. He had been a farm-labourer, &c., and is stated to have had no illness prior to this fatal one. The fever had been caught by visiting a sister who died of it a week before his own admission. At the *post-mortem* examination no ulceration of Peyer's patches was found. The mesenteric glands were enlarged, and in the peritoneal fold, behind the cæcum, was a gland almost the size of a bantam's egg. On the stomach being opened, and, according to custom, water poured into it, it was noticed that the water did not escape. This led to further examination, when it was found that the pylorus was occluded by the cyst as above described. On subsequent questioning, the man's widow stated that she was quite certain her husband had never been liable to vomiting, or to any especial symptoms of stomach affection. As the fluid from the inner part of the cyst might easily be pressed out into the external half, it was easy to account for the fact, that there had been no indications of obstruction during life.

Mr. HUTCHINSON for Dr. SLOANE, *3rd of March*, 1857.

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26. *Case of Polypus ejected from the Stomach.*

W. C., a female, æt. 19, of robust appearance, had enjoyed good health till about twelve months ago, when she had an attack of herpes zoster on the left side. This yielded to the usual treatment, and, in about a week after the attack, she regained her usual state of health. Menstruation had always been regular. A short time after the attack of herpes she began to suffer from distention at the stomach, chiefly after meals, which was attributed to flatulence. This was subsequently followed by pain, which was always increased after eating. The pain, at first only present slightly, and occasionally through the day, except after meals, became very bad during the night, and her sleep was disturbed. For the last three months she had lost much weight—during six weeks as much as a stone and a half. The bowels had always been regular, but the urine had been

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turbid on cooling, since the attack of shingles; sometimes plentiful in quantity, and at others scanty. She had frequently felt faint with the pain at the stomach, which latterly had also extended to the left side. No sense of soreness or tenderness externally. About a month ago Mr. Beardsley prescribed an alkali with a bitter infusion, which somewhat relieved her pain, and the flatulence, &c., the case being considered merely as a derangement of the stomach. He heard no more of the case. On Tuesday last, however, when, on going to her usual employment, she felt suddenly faint, and vomited the tumour laid before the Society. At the time of its rejection, she felt what appeared to be another rising in her throat, but she swallowed it again. She felt very faint and poorly all the subsequent day, with a great deal of soreness at the pit of the stomach, extending to the left side. Her appetite has failed her during this week, but she now feels as well as before she vomited, though she has at intervals ejected a little blood, &c., which has risen in her mouth. The pulse is eighty-four. Her appearance is now somewhat sallow and pale. She often feels her hands and fingers numb, and she suffers from a constant creepy-feeling of the flesh. For the last twelve months she has had much flatulence, and her appetite has varied, being sometimes rather voracious, and at other times the contrary. The bowels have always been quite regular, and she has never suffered from diarrhœa. The tumour, which is about the size of a small chestnut, Fig. 3, Plate IV. appears to have been attached by a very small pedicle to the mucous coat of the stomach. It was very firm when vomited, and looked like an unshelled egg. It appeared to be very vascular, and the anastomoses of the blood-vessels, on its surface, were well discerned by reflected light, and, indeed, by the unaided eye. The cut surface of the tumour, Fig. 4, presented small foramina or cells, and the specimen, when examined by the microscope, was found to consist of a mass of connective tissue, of blood-vessels, and granular cells, and granular particles, apparently fatty, covered by a layer of mucous membrane. The membrane consisted, as usual, of a basement layer, the surface of which was covered by a layer of columnar epithelium, Fig. 5. These appearances are well seen in the figures drawn by Mr. Tuffen West,

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from his own dissection. The characters described, shew the tumour to be of a simple character, and to correspond to the structure known as the gastric polypus. It is a rare form of disease, not often reaching the size of the present specimen. Mr. Beardsley very properly assigns the presence of the gastric symptoms to the existence of this or similar tumours, some of which probably still remain, as the symptoms, though mitigated, have not disappeared. He also recognises a connexion between the occurrence of the shingles, and the presence of this tumour.

Dr. Quain for Mr. Amos Beardsley, *3rd of March*, 1857.

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27. *Specimen of a Salivary Calculus.*

The patient, æt. 30, a German of regular habits, has never smoked for the last two years, but has suffered from general debility. Sixteen years ago he first felt a small lump in the left submaxillary region; with the exception of occasional pain, referred to the angle of the jaw, and relieved by gentle pressure, and by inclining the head downwards to the left and outwards, it did not give him much inconvenience till lately, when the under surface of the tongue became sore and excoriated.

On the 1st of March he complained of sore throat, and the tonsils were found enlarged; on the 5th he felt a hard substance working its way out of Wharton's duct, on the left side of the frænum linguæ. It came away readily, no blood or other discharge followed, there was neither ranula nor abscess. The swelling of the gland is gradually subsiding. The calculus is about three-quarters of an inch in length, is of the thickness of a small goose quill and consists of concentric layers.

Dr. W. Ogle for Dr. Webb, *17th of March*, 1857.

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28. *Cancer of Stomach. Ulcerative Communication between the Stomach and Transverse Colon. Fistulous Openings through the Abdominal Parietes.*

J. H., a coachman, æt. 63, was admitted into St. Mary's Hospital, under the care of Mr. Ure, on the 11th of November,

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1853. He gave the following history of himself. About eighteen months before, whilst mounting a carriage, he struck his left side against the step. This caused much pain for some time, but he continued working for nearly six months. An abscess then formed just below the left costal cartilages; he lost his appetite, suffered greatly from indigestion, and got much thinner. The abscess increased to the size of a large orange, and he was admitted into St. George's Hospital. Two days after, the abscess was opened, and pure pus escaped; he experienced great relief, and, at the end of five weeks, was able to return to work. Six months after, another abscess formed in the same locality. He then became an out-patient at St. George's Hospital, where this abscess also was opened. The fistulous openings from both abscesses continued discharging up to the period of the patient's admission into St. Mary's Hospital. At this time the following report was made:—

"There is a hard brawny swelling, extending about twelve inches laterally, and six inches from above downwards, situated over the cartilages of the left false ribs, and region of the stomach. There are two fistulous openings, from which a little, thin, clear discharge exudes. One of these is situated in the epigastrium, near the middle line. Through this a probe passes obliquely inwards towards the abdominal cavity for two inches, and its point can be pushed about for five inches from side to side. Much pain is complained of in the left side, at a spot five or six inches to the left of the median line, which is red and fluctuating. The appetite is bad; the patient can eat no meat; (no mention is made of vomiting). Has very frequent micturition during the night. Urine not albuminous. Is much emaciated; formerly weighed twelve stone, now weighs only nine."

He was treated with tonics, steel, quinine, &c., and put upon a nutritious, non-stimulant diet of fish, milk, jelly, &c. An opening also was made into the reddened spot, which gave great relief.

While the patient was under observation, a very fetid odour was frequently noticed to proceed from the fistulous openings, and quantities of a fetid gas would escape from them, either on the introduction of a probe, or with each inspiration.

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No improvement took place in the symptoms; on the contrary, at the beginning of December they became aggravated. The fistulous openings assumed a very unhealthy appearance, and discharged a quantity of very fetid fæcal-smelling matter. There were frequent rigors; great prostration; sallow countenance; œdema of the legs; weak, irregular, and intermitting pulse; dry brown tongue; and vomiting. The vomited matters were distinctly of a fæcal odour, but did not resemble fæces in their general appearance. From this time the patient gradually sank, and died on the 11th of December.

Post-mortem examination.—The body was examined on the day after death, and the following appearances presented themselves:—there were three fistulous openings, with sloughy margins, in the left part of the epigastric region. These fistulous openings led to, and opened into a large sloughy "foyer," which communicated both with the transverse colon and the stomach. The anterior wall of the stomach, for about one-third of its extent from the pyloric extremity, was destroyed by cancerous ulceration, so that it became replaced by that portion of the abdominal wall and thickened peritoneum forming the anterior boundary of the sloughy "foyer." The whole of the pyloric third of the stomach not destroyed by ulceration, was occupied by a hard mass of scirrhus, the surface of which was covered with fungoid growths, and presented a sloughy ulcerated appearance. This mass almost completely obstructed the opening into the duodenum. On slitting open the transverse colon, the opening into the sloughy "foyer" was found large enough to admit a crow-quill. The coats of the bowel, and even the margins of the fistulous opening, were quite free from cancerous deposit; its mucous surface presented a blackish discoloration. The peritoneum in the neighbourhood of the disease was thickened and opaque; and the liver and spleen were connected to the surrounding parts by numerous firm adhesions. There was cirrhosis of the liver, and there were numerous cysts, and other evidences of disease in both kidneys.

Remarks.—Although most writers on the pathology of the stomach, allude to the possibility of the establishment of a com-

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munication between it and the colon, as the result of either perforating ulcer or cancerous disintegration, the lesion is an exceedingly rare one. The cases recorded, as far as I have been able to ascertain, do not exceed twenty, and in all the London museums, there are only three or four illustrations of it.

After a careful consideration of the facts, the following appears to me to have been the history of the lesion in this individual case. An abscess forms in the abdominal wall, the result of injury. This, at first, is quite unconnected with the stomach, for on its being opened, pure pus escapes. About the same time, and possibly from the same exciting cause, cancerous deposit takes place at the pyloric extremity of the stomach; the cancerous matter ulcerates; the stomach contracts adhesions with the abdominal wall, at a part corresponding to the abscess, and also with the colon. The ulceration of the stomach spreads, until its cavity communicates with that of the abscess, and fetid gas escapes from the fistulous openings in the abdominal wall. Lastly, the ulceration advances from this cavity, and penetrates the adherent colon, so that fæcal-smelling matter is vomited, and escapes from the fistulous openings.

This case so far corroborates the opinion entertained by Dr. W. T. Gairdner, of Edinburgh,* who, from investigating a limited number of instances of this lesion "was inclined to believe that it would be found that fæcal vomiting was to be looked for chiefly in those cases in which the pyloric opening was free, and in which, therefore the stomach was not overloaded with its own proper contents; while vomiting of food was to be expected in the opposite class of cases." Here, there was obstructed pyloric orifice, with vomiting of matter, which exhibited a fæcal odour, but did not in any other respect, resemble fæces. It is to be observed, however, that much fæculent matter could not in this case have passed from the colon into the stomach, owing to the small size of the opening in the former organ. In most of the cases in which fæcal vomiting has been a characteristic symptom, the communicating opening has been large enough to admit two or three fingers; and it would seem questionable whether the

* "Edinburgh Medical Journal," July, 1855, p. 81.

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occurrence of fæcal vomiting is not dependent on the size of the opening rather than on the absence of constriction of the pylorus.

Dr. MURCHISON, *7th of April*, 1857.

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29. *Close Stricture of the Rectum, with a large Abscess at the back of the Rectum, opening into the Bowel.*

G. W., a married woman, æt. 38, was admitted into the London Hospital, on the 9th of September, 1856, on account of a disease of the rectum. She stated that her bowels had long been costive, seldom acting unless she took castor oil, and that her motions were generally passed with pain, and had been attended latterly with a copious purulent discharge. She did not give a very clear account of her case; but it was ascertained that her chief symptoms had existed about six months. On examination, some flattened external piles were found fringing the anus. On passing the finger into the rectum, a tight stricture was felt high up, about three inches from the anus. It felt uniformly indurated, and was so close as only to admit the tip of the finger. She had also a reducible femoral hernia on the right side. Attempts were made to dilate the stricture, without, however, any satisfactory result; and after she had remained in Hospital some weeks, a low form of peritonitis set in, and she died on the 8th of November.

On *post-mortem* examination, the body was found somewhat emaciated. There were marks of recent peritonitis, the serous membrane being injected, and its visceral layer coated with patches of plastic lymph. Between two or three pints of sero-purulent fluid were found in the cavity. In detaching the rectum, a large abscess seated behind it, and in contact with the sacrum was opened, and the second sacral vertebra was found carious. There was no communication between this abscess and the cavity of the abdomen, but the peritoneum in its vicinity was adherent and thickened. The walls of the abscess were thick and consolidated, and its inner surface presented a dark, slate colour. The upper part of the rectum, in front of the abscess, was greatly contracted to the extent of two inches and a half. The mucous membrane at this contracted part was eroded,

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and ulcerated, and its follicles enlarged. There were two openings of communication between the rectum and the abscess, of a size sufficient to admit the passage of a No. 8 bougie.

A copious purulent discharge from the bowel is a common symptom of stricture of the rectum. Its chief source in this instance was evidently the circumscribed abscess at the back of the bowel. Notwithstanding the chronic character of this abscess, there can be little doubt that the contraction in the rectum was the original disease, subsequent ulceration in the mucous membrane of the bowel having led to the formation of matter in the structures external to it.

Mr. T. B. Curling, *5th of May*, 1857.

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30. *Stricture of the Sigmoid Flexure of the Colon.*

The specimen was removed from a lady, æt. 35, the mother of twelve children. Her general health had always been tolerably good; for some years she had been subject to constipation, the action of the bowels being always attended with great straining. On the 25th of March, 1857, symptoms of intestinal obstruction set in, attended with stercoraceous vomiting. She lived till the 26th of April; a few days prior to which, a considerable quantity of fæces passed, per anum. An examination after death revealed the intestines enormously distended, and highly congested. A stricture existed at the sigmoid flexure of the colon, above which the intestine was greatly enlarged, and ulcerated in its whole circumference.

The patient was attended by Mr. E. B. Phillips, of Hales Owen, who sent this preparation to me.

Mr. Ashton, *5th of May*, 1857.

II. LIVER AND APPENDAGES.

31. *Cancer of the Liver, involving the Gall-Bladder. Obliteration of the Cystic Duct. Gall-Bladder distended, and containing two Gall-Stones.*

A. B., a female, æt. 53, was admitted into St. Mary's Hospital,

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the 29th of August, 1856. She had been suffering from pains in the loins and abdomen for two months, and, on admission, she had also slight jaundice, and obstinate constipation. These symptoms increased, and a week after there was superadded incontrollable vomiting. All treatment proved perfectly unavailing; the jaundice became more marked, the constipation more confirmed, and the patient grew gradually weaker, till her death, on the 28th of September.

On *post-mortem* examination, the transverse colon was found firmly glued to the great curvature of the stomach, and all the intestines matted together, by cancerous deposit on their peritoneal surface. There was a stricture of the rectum from similar deposit, commencing one inch and a half from the anus, and extending upwards for three inches. The only portion of the liver affected was the lobus quadratus. In this there was a cancerous deposit, the size of a small orange, which involved, and had obliterated the cystic duct. The coats of the gall-bladder, for one-fourth of their extent from the duct, were thickened by deposit. The anterior three-fourths appeared free from disease. The whole gall-bladder was of a pale colour, and much distended, so as to project two inches in front of the anterior margin of the liver. On opening it, it was found to contain a milky, flaky fluid, exhibiting under the microscope numerous epithelial scales, and two gall-stones about the size of marbles. There was no trace of ulceration in any part of its lining membrane, and no adhesion between its outer surface, and any of the viscera; bile was found in the duodenum. The mucous membrane of the stomach, the spleen, kidneys, and lungs, was free from disease.

Remarks.—In this case there were present all the conditions which have been described as favourable to ulcerative perforation of the gall-bladder, *viz.*, obstruction of the cystic duct, distention of the gall-bladder, and the presence of gall-stones. No trace, however, of any ulceration could be detected.

Dr. Murchison, *18th of December*, 1856.

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32. *Cancer of the Liver. Destruction by Cancerous Ulceration of the Gall-Bladder, and communication of the resulting cavity with the Transverse Colon. Stricture of the Colon.*

S. P., a man, æt. 56, by occupation a coach-painter, came under my care on the 14th of August, 1856. When a young man, he stated, that he had had a severe attack of jaundice, preceded by cramps in the stomach. He had also had typhus fever, and fourteen years before I saw him, he had a severe attack of rheumatic fever, followed by palpitations and other symptoms of cardiac disease. His father had lived to a great age, and his mother died at eighty-six of cancer of the uterus. He was his mother's last child, and was born when she was nearly fifty.

Three months before he applied to me for relief, he began to suffer for the first time from a pain in the region of the liver, but he continued regularly at his work till the middle of July. About this time he was seized with severe abdominal pain, vomiting and purging. He continued at work, although irregularly, for a fortnight longer, but on the 1st of August, the vomiting and purging still continuing, he was obliged to take to bed. On the 7th of August he became jaundiced. The following notes were taken when he was seen by me on the 14th of August:—"Is very much emaciated, and very weak, so as scarcely to be able to rise up in bed; skin and conjunctivæ are of a deep yellow colour, and the countenance has an anxious aspect expressive of inward pain. The tongue has a yellowish fur. Vomiting still continues, almost everything he swallows being immediately rejected, and sometimes apparently before it reaches the stomach. Bowels relaxed. Two or three days ago, his wife states, he passed by stool a quantity of black matter like blood. He complains of severe pain in hepatic region, coming on at intervals, and of a sharp shooting character. Hepatic dulness extends four inches below the margin of the ribs; and a tumour can be felt in the region of the gall-bladder, two or three inches in diameter, immoveable, apparently connected with the liver, and very painful on pressure; the patient does not sleep on account of the pain; pulse, one hundred. A

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diastolic blowing murmur is heard over the middle of the sternum."

He was ordered milk diet, wine, opiates, and various remedies to check the vomiting, including naphtha and dilute hydrocyanic acid. Nothing, however, proved of any avail; he gradually sank, and died on the 19th of August. Previous to death, his stools had assumed a perfectly natural colour and consistence.

Post-mortem examination, thirty hours after death.—There were some opaque patches on the surface of the heart, and several small vegetations on both the mitral and aortic valves. The lungs were healthy.

There was no effusion into the peritoneal cavity, and the spleen and kidneys were normal. Scattered throughout the substance and over the surface of the liver, were a number of dull-white masses of morbid deposit, varying in size from that of a pea to that of a small orange. Those on the surface were depressed in the centre, and from all of them exuded, on pressure, a milky juice containing a multitude of so-called "cancer cells," and free nuclei. These cells varied in size from $\frac{1}{250}$ths to $\frac{1}{1500}$ths of an inch, and in form were rounded, elliptical, fusiform, pear-shaped, &c., while their nuclei were large and well defined. Among them were a few "mother cells." The transverse colon was firmly adherent to the anterior margin of the liver, at a part corresponding to the situation of the gall-bladder, and on slitting up the bowel, its interior was found to communicate by an opening as large as a half-penny piece, with a cavity hollowed out in the substance of the liver, measuring two inches and a half from before backwards, and one inch and a half from side to side. The walls of this cavity presented an irregular sloughy aspect, being composed of disintegrating hepatic and cancerous tissue, and its interior was filled with a dark-brown pultaceous fluid, containing a piece of potato skin, and other *débris* of the food. This cavity corresponded exactly in position to the site of the gall-bladder, no trace of the walls of which could be seen. The remains of the obliterated cystic duct and artery were made out embedded in a mass of cancerous deposit, the size of a Spanish nut, which also compressed but did not obliterate the common hepatic duct.

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The margins of the opening in the transverse colon, and the whole circumference of the corresponding portion of the bowel, were thickened by deposit, which narrowed the calibre of the gut, so as to produce a stricture, barely admitting the point of the finger. The bowel to the right of this stricture was much dilated, and exhibited on its mucous surface a number of superficial circular ulcers, the largest being about the size of a silver penny-piece. The continuation of the gut beyond the stricture was contracted. There was no disease of any other portion of the intestines or of the stomach, but the pyloric extremity of the latter was pressed upon by the cancerous deposits of the liver.

Remarks.—The pathological history in this case was probably somewhat as follows:—

1. Cancerous deposit in the liver.
2. Spreading of this deposit, so as to involve the coats of the gall-bladder, and contiguous transverse colon.
3. Ulcerative disintegration of the walls of the gall-bladder, and of a portion of the adhering colon.

It is not unusual for the gall-bladder to become involved by cancerous disease of the neighbouring hepatic tissue, and Rokitansky also describes a primary cancer of the gall-bladder. It seems very rare, however, for the disease to spread in the remarkable manner described above. I have not been able to meet with a similar case. It is true that most writers on diseases of the liver, such as Bonnet, Portal, and Dr. Budd, have described cases in which the gall-bladder has been found to communicate with the duodenum or transverse colon, but the manner in which this is stated to have been brought about has been as follows:—"the cystic duct becomes obliterated by a gall-stone, or some morbid deposit, and as a consequence the gall-bladder becomes distended and inflamed, and contracting adhesions with a contiguous piece of bowel, ulcerates into its cavity." Dr. Budd also observes, "that in all such cases with which he is acquainted, the ulceration has been produced by gall-stones in the gall-bladder." Such an explanation does not appear applicable to the case under consideration.

The severe abdominal pain, vomiting, and purging with

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which the man was seized about a month before his death, mark in all probability, the completion of the perforation of the coats of the colon. Dr. MURCHISON, 18*th of November*, 1856.

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33. *Calculus from the Gall-Bladder, obstructing the Intestine. Perforation of the Gall-Bladder communicating with the Duodenum.*

A. M'D., æt. 46, was admitted into the Middlesex Hospital, on the 29th of January, 1856, under the care of my friend, Dr. Stewart, to whose kindness I am indebted for the notes of this case. Her general health was good, but, for many years past, she had been of a costive habit, the bowels being seldom moved without taking aperient pills. She has been subject to bilious attacks, with vomiting of green, bitter matter; and there was loss of appetite, and excessive flatulence, which increased after meals.

Twelve days before admission she took two antibilious pills, which acted freely the following day. Vomiting took place at the same time, and continued with little intermission ever afterwards. The motions and vomited matters were of a green colour. Sleep was much disturbed. Two days after this she was seized with sudden, severe, sharp pain in the right iliac region, where the tenderness, on pressure, was still acute. This pain continued with remissions until admission. She had no motion for ten days from this time, *i.e.*, from the 19th to the 29th of January. On admission, an injection, consisting of a pint of gruel and some castor-oil was administered; it passed up entirely, but with great pain, and was soon discharged, with several large hard scybalous masses. The abdomen then became flaccid; it was slightly dull to the right of the umbilicus, but elsewhere perfectly resonant. Her countenance was rather pinched and anxious, and the cheeks florid. Tongue dry, and covered with a thick, yellow fur on the dorsum, moist and clean at the edges; thirst very urgent. Pulse eighty, very small. Slight sonorous ronchi on the right side of the chest; breathing healthy on the left side. Heart's sounds normal. A warm bath was ordered, to be followed by poppy fomentations, and an opiate pill.

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30th of January.—Passed a tolerable night, and notwithstanding a constant sensation of nausea, has not vomited since admission. Two pints of injection passed up without difficulty or pain, and after being retained half-an-hour returned without a trace of fæculent matter. The abdomen now much more tense and tympanitic; still painful on pressure.

Ten P.M.—Countenance less anxious; thirst very great; has voided a pint of clear urine this afternoon. Nausea continues, but she has not vomited until just now, when she suddenly raised herself on her elbow and vomited more than half a pint of dark brown and very offensive stercoraceous fluid. The vomiting and retching continued for several minutes, till she had brought up about three pints of this fetid fluid. Pulse, seventy-eight.

31st of January.—There was no recurrence of vomiting till eleven A. M., when she vomited about a pint more of fluid, having the same colour, but without the fæculent odour.

The abdomen became more and more distended; the pain increased; no motion passed; there was frequent retching; exhaustion supervened and she died rather suddenly.

Post-mortem examination.—On opening the abdomen the intestines appeared very much distended, and were in some places adherent to each other by recent lymph; the great omentum was puckered up and adherent to the intestines. On separating the intestines a solid body about the size and shape of a cork was found to block up the small intestine about the middle of the ileum, where it fitted like a plug. At the point of obstruction the gut was bent upon itself, the adjacent peritoneal surfaces being slightly adherent by recent lymph. The intestine seemed to become suddenly smaller immediately below the obstruction, but above this point it was greatly distended and filled with dark greenish fæculent matter, in which were found ten small angular biliary calculi, about half the size of hazel nuts. The dilated portion of the intestine was dark; and when laid open, the mucous membrane was found much congested, in some parts covered by adherent lymph, and a number of small roundish ulcers were scattered over the surface. The obstructing body was discovered to be a large

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biliary calculus. It was perfectly cylindrical, measuring nearly four inches in circumference, and one inch and a quarter in diameter. Its external surface was uniformly nodulated, the extremities being rather smooth. When divided transversely it exhibited a crystalline appearance; crystallization seeming to have taken place round the longitudinal axis of the calculus.

Below the obstruction the intestine was much contracted and pale throughout, containing only a little thickish mucous secretion. The colon was almost empty. The stomach contained some greenish fæculent matter and one small angular biliary calculus. The gall-bladder was firmly adherent to the duodenum, at the point where it turns downwards to become perpendicular, and a well-defined communication existed between these two parts, large enough to admit a finger easily. The gall-bladder was contracted and converted into a small fibrous pouch; but there can be no doubt that the calculi passed through this perforation, although the opening was now much smaller than the calculus causing the obstruction. The liver weighed fifty-eight ounces, and appeared tolerably healthy, though rather dark coloured. The heart, lungs, and kidneys were not diseased.

Dr. Van der Byl, *2nd of December*, 1856.

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34. *Earthy Degeneration of some Portions of the Liver. Dropsy after Scarlet Fever.*

H. W., a boy, æt. 16, was admitted into St. Thomas's Hospital on the 12th of February, 1856, for scarlatinal dropsy, of which he died on the 5th of April. Nothing unusual or particularly worthy of notice occurred in the course of the disease. It did not appear that he had ever laboured under any affection of the liver.

Autopsy.—The 7th of April, 1856. General appearance; of ordinary stature, and not emaciated. The body was unusually pale and waxy-looking, and extremely œdematous.

Chest.—Heart and pericardium healthy. The pleural cavities contained a considerable amount of serum, and the lungs, which were healthy, were partially compressed by it.

Abdomen.—The peritoneal cavity held about half a pailful of

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serum. The liver was of ordinary size, but its capsule was a little opaque. On section, the substance of the organ was found to be rather pale, and somewhat indurated, and studded with spots and streaks, and, in some parts, an imperfect network of buff-coloured material. These deposits stood out from the surface, and felt hard and gritty, and, altogether, their characters were such as to suggest the idea that they were seated in the parietes of small vessels. They were scattered throughout the whole of the liver, but not uniformly, being most abundant in the left lobe, especially in its right margin; and, throughout the rest of the organ, they were arranged for the most part in irregular groups. On looking closely at the outer surface of the liver, they could be distinctly seen in many places forming a network beneath the capsule. There was no apparent disease of the larger portal, or hepatic vessels. Under the microscope the gritty deposits were found to consist, in great measure, of earthy matter, which dissolved in acetic acid. This appeared to be situated in the cells of the liver, for it existed under the form of angular refractive colourless masses, of the same size, for the most part, as the liver cells, similarly arranged, and evidently occupying spaces which had been originally occupied by healthy liver cells. None of the latter, however, appeared to be mixed with them. Clearly none of the deposit had occurred in the vessels of the liver. After the earthy matter had been dissolved out by acetic acid, the animal basis that was left behind was found to present a closer resemblance to liver cells than it had done, when impregnated by earthy salts; but it was colourless, and no nuclei were satisfactorily seen in it. The cells of those portions of the liver, that looked healthy to the naked eye, were quite healthy under the microscope, and this healthy character extended quite up to the margins of the earthy deposits.

The kidneys were natural in point of size. Their cortical substance, though rather paler than usual, was studded with small congested points and patches. When submitted to microscopic examination, it appeared that many of the renal tubes had an accumulation of epithelium within them, but this was an appearance that might have been fallacious. The Malpighian bodies,

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however, were universally diseased. Their dimensions were, as nearly as possible, normal; but their tufts of vessels were somewhat masked, and there was a perfectly distinct concentric marking, which extended from the capsules for some little distance inwards. The same appearances were observed in those Malpighian bodies which stood out from the edge of a section. In very few of the latter had the capsule become ruptured, as one usually finds it in a healthy kidney; and, in those few, in which laceration had occurred, the vascular plexuses were contracted and condensed. It appeared pretty evident that there had been an effusion of some coagulable material between the walls and the tufts of vessels of the Malpighian bodies.

The spleen was small, and the other abdominal viscera were healthy.

The above case furnishes a not uninteresting example of the pathological condition presented by the kidneys, in cases of not immediately fatal dropsy after scarlet fever; it is recorded however, chiefly, on account of the singular changes that had taken place in the structure of the liver. It seems most probable, that the appearances discovered in that organ were not due to any form of disease in progress at the time of death, but were the *post-mortem* indication, and the result of some affection, the active condition of which had long since ceased. But, as to what the nature of that disease was I do not feel prepared to offer any opinion; neither would I undertake to maintain that the earthy deposit was seated within the cells of the liver, although, from the description above given, it will be seen that there was some reason to suppose that such was the case.

Dr. Bristowe, *2nd of December*, 1856.

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35. *Specimen of Hepatic-intestinal Calculus.*

This large calculus was found by Mr. Jakins, in the duodenum of a man, whose history, being a dissecting-room subject, is unknown, further, than that he died at the age of eighty-seven, in St. Pancras Workhouse, of natural decay. The specimen is of much interest when viewed in connection with one recently

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shewn to the Society by Dr. Van der Byl, as it illustrates very strikingly some points in the pathology of these cases. The calculus is of an oblong shape, measures three inches in length, and three and three-quarter inches in circumference. It weighed, after being dried in the air, four hundred and fifty grains. It is seen to be made up of three portions articulated together, and on the middle division there are two lateral facets, showing that there had been formerly two other portions. The calculus was found lying in a cul-de-sac in the right side of the duodenum about equidistant from the pylorus and the entrance of the ductus communis choledochus into the intestine. The outer wall of the cul-de-sac was firmly adherent to the surrounding parts, the gall-bladder included, by old standing adhesions. The gall-bladder was very small and contracted, the common duct on the other hand was abnormally dilated.

On breaking the calculus its texture was found to be crystalline towards the circumference, amorphous in the interior. On analysis I found it to consist in one hundred parts of—

Cholestearine . . .	90·346
Mucus	2·218
Coloring matter and resin . .	4·242
Inorganic Salts . . .	0·661

Thus shewing it to be a biliary calculus, containing, however, more than the average amount of cholestearine, and there can be little doubt that it was formed in the gall-bladder. The question is, how came it to lodge in the cul-de-sac of the intestine? If it was expelled from the ductus communis choledochus, the opening of the duct must have been immensely distended to allow the passing of such a large body. After its expulsion it must have been carried upwards by the peristaltic action of the intestines, and become lodged in the dilated portion of the duodenum. To me it appears more probable, from the great size of the calculus, the presence of a cul-de-sac, and the old standing adhesions between the duodenum and neighbouring tissues, that the stone ulcerated its way through the walls of the gall-bladder and other structures into the intestine, and formed the pouch for itself.

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The dilated state of the gall-duct can easily be accounted for, on the supposition that the stone, by its presence in the gall-bladder, prevented the entrance of the bile; the bile would therefore, by accumulating in the ducts, gradually dilate them. After the stone had found its way into the intestine, the gall-bladder would contract, and permanently remain in that condition, the dilated ducts still continuing to supply its office.

As was before said the specimen is of much interest when taken in connection with Dr. Van der Byl's specimen recently exhibited. It illustrates well the fact, that the evil effects arising from hepato-intestinal calculus, depend more on the situation than upon the size of the stone. In Dr. Van der Byl's case, a much smaller stone speedily caused the death of the patient, and here we see how a very large one may remain a long time in the alimentary canal without giving rise to any disagreeable symptoms. Had it become dislodged from the cul-de-sac it could not have passed down the intestines, owing to its size. Dr. HARLEY, *16th of December*, 1856.

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36. *Abscess of the Right Lobe of the Liver, communicating with the Upper Extremity of the Ascending Colon.*

J. P., a man, æt. 40, was admitted into St. Mary's Hospital under the care of Dr. Sibson, on the 18th of April, 1856.

He stated that he had always enjoyed good health, and that, although he had been in the habit of drinking a good deal of malt liquor, he had never been addicted to spirits, and had, on the whole, been a temperate liver. About a month before admission he "took cold," and was seized with a shooting pain in the right hypochondriac region, which, on the second day, became so extreme, as to prevent his working. He went to bed, where he remained until the day of admission, the pain in the right side continuing without intermission, except when relieved by opium.

On examination after admission, there was found to be great fulness in the right hypochondriac and lumbar regions of the abdomen, with a feeling of a resisting mass extending downwards as far as the crest of the ilium, and forwards to within

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three inches of the linea alba. This space was universally dull on percussion, and the dulness was continuous with that of the linea. The swelling was of a doughy consistence, and although no distinct fluctuation could be made out, yet a peculiar sense of tremulousness was conveyed to the finger on percussion. The tongue was loaded, the bowels rather confined. The urine was voided three or four times a day; acid; specific gravity 1·020. The pulse was one hundred and eight, weak.

Poultices of linseed meal were applied over the swelling, while iodide of potassium, (gr. ij ter. die), gentle laxatives, opiates, and stimulants were prescribed internally.

On the 24th of April he had an attack of erysipelas of the face, which continued for four or five days. On the 26th of April, during this erysipelas, he was seized with violent diarrhœa with purulent-looking stools. This ceased in a great measure after four or five days, and he then felt himself greatly better; his appetite had improved, the pain had gone, the swelling and dulness were much diminished, and the calls to make water, less frequent. He continued to improve until the 11th of May, on which day he had a return of the severe pain and diarrhœa. The pain was referred chiefly to a spot about two inches below the margin of the ribs, in a line with the right nipple. The stools where of a light buff colour and very offensive. This diarrhœa resisted all treatment, and soon the patient's constitution began to give way. He became liable to febrile exacerbations towards evening, and profuse perspirations during the night. His pulse varied from one hundred to one hundred and twenty-five and was very weak, his tongue became dry and brown, and he gradually sank until death at ten P. M. the 27th of May. Four days before death, the swelling in the right side was observed to have very greatly diminished, the dulness in the right lumbar region not extending farther forward than a perpendicular line, drawn from the middle of the crest of the ilium to the ribs.

Post-mortem examination forty-one hours after death.—On opening the abdomen there were found extensive adhesions of the viscera, and other indications of peritonitis, which were, however, entirely limited to the right side, the peritoneum on the left side being

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perfectly normal. These adhesions of the viscera on the right side rendered their examination extremely difficult. The whole of the anterior margin of the right lobe of the liver was firmly adherent to the peritoneal surface of the abdominal wall, while the under surface of the anterior edge along with the gall-bladder, was in intimate union with the transverse colon. The texture of the liver was pale. In the lower part of the right lobe was an abscess, as large as two fists, containing a quantity of fluid fæculent matter, of a light yellow colour. This abscess involved almost the whole of that portion of the lobe to the right of the fissure of the gall bladder, and extended to within half an inch of its upper surface. The upper two-thirds of the walls of the abscess were formed by hepatic tissue, and were rough and ragged, without any limiting membrane. The lower part was completed by the kidney, the anterior layer of the fascia lumborum, and about three inches of the ascending and transverse colon. This portion of the colon communicated freely with the cavity of the abscess. Its upper wall, next the abscess, presented a sloughy cribriform appearance; all that remained of it being a few narrow bridles, passing transversely and easily torn across. There was extensive ulceration of the mucous membrane of the ascending colon, and slight ulceration of Peyer's patches in the ileum.

The kidneys were anæmic, and the spleen soft and pliable. The thoracic organs were healthy, the left cavities of the heart containing blood, the right being empty.

Remarks.—Although at the time, it was a matter of question whether the abscess in this case had originated in the liver itself, or in the cellular tissue in the neighbourhood of the kidney, my own opinion, after a careful examination of the parts, was that it did originate in the liver; and at all events there can be little doubt, that this organ became involved at an early stage, and to a very great extent. Primary abscess of the liver is a rare lesion in this country. In the tropics, however, where it is more common, the evacuation of the abscess into the colon, as in the above case, or into some other part of the bowel, is not infrequently met with, and indeed constitutes a not uncommon mode, in which a spontaneous cure is established. Of one hundred and

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twenty-four cases of abscess of the liver, mentioned by Dr. Morehead, in his "Researches on the Diseases of India," the abscess opened into the stomach or intestine in three cases; and out of three hundred cases of abscess of the liver, collected by Mr. Waring, of the Madras Medical Service, this occurrence took place in nine cases, or three per cent. Dr. Morehead, however, states that his impression is, that such a termination of hepatic abscess is not so common as is generally believed.

In the above case the abscess appears to have burst into the bowel on the 26th of April, just a month before death, as indicated by the sudden and severe diarrhœa, with puriform stools. The temporary cessation from the diarrhœa after four days, and the great amelioration of the general health, would seem to point to a closing up of the aperture, and an attempt by nature at a spontaneous cure; while the return of the purging, along with the severe circumscribed pain, were probably dependent on a re-establishment of the aperture, with inflammation and ulceration of the bowel. The existence of the ulceration of the bowel was important, as regards the relation supposed to exist between dysentery and hepatic abscess, as cause and effect. Dr. Morehead and most Indian observers are opposed to the theory of the pyæmic dependence of the hepatic abscess upon dysentery. This case tends to corroborate their opinion, as the abscess existed long before there were any signs of intestinal irritation, the bowels in fact, being at first constipated rather than the reverse.

Dr. Murchison, *16th of December*, 1856.

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37. *Syphilitic Disease of the Liver.*

A. H., æt. 39, died under Mr. Hilton's care, in Guy's Hospital, in December, 1856. He had led a very dissipated life, had had syphilis, and taken much mercury; this drug, however, he stated was not given him for the venereal disease, but for a fever which he suffered in China in 1842. The disease of the cranium, for which he entered the Hospital, had been increasing for three years before his death, commencing with a slight exfoliation of the bone on the right side, and advancing until a large part of the calvaria was destroyed. He was in the Hospital several times

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for this complaint, and on his final admission in November 1856, he was in an extremely cachectic condition, and scarcely a sound portion of bone remained on the head, the latter being covered with cicatrices and purulent sinuses. He died shortly afterwards of pleuro-pneumonia. Upon examining the liver, an indentation like a cicatrix was seen upon the upper surface of the right lobe, and upon cutting through this, the structure, for a short distance beneath, was seen to be contracted, and indurated, from the presence of a dense fibrous tissue infiltrating the parenchyma. Although this puckered part was not, as a whole, accurately defined, yet below, it had a distinct rounded margin, Plate III. Figs. 1, 2, and the new material appeared to have been originally deposited as two rounded nodules. Such nodules were seen scattered about in the neighbourhood, and amounted to about fifty in number. They consisted of round, hard, white masses, the size of peas, and at first sight might have been mistaken for cancerous tubercles; unlike these, however, they were situated, not on the surface, but in the interior of the organ, being formed within Glisson's capsule, and thus, everywhere, in close contact with the portal vessels. These nodules were of a pearly-white colour, very firm, hard, and dry; they cut sharply as cartilage, and did not tear as fibrous tumours; and they emitted no juice on pressure. The microscope shewed them to consist of an amorphous, albuminous, translucent material, which by the addition of re-agents, was seen to have somewhat of a fibrous arrangement, and interspersed with nuclei and fatty granules; in fact, a very low organizable deposit. The testes were much wasted, the glandular structure being replaced by a dense fibre tissue, which in some places was collected into nodules, resembling somewhat those in the liver. The calvaria had lost about half of its original bone, and nearly all the remainder was in a state of necrosis. The condition of the liver here found, appears to correspond to that described by some foreign writers as a syphilitic disease of the organ, and being a form of cirrhosis, in which the new fibrous tissue, instead of being diffused through the liver in the course of the vessels, is deposited in distinct nodules. Thus, in "Wedl's Pathological Histology," translated by Busk, is the following:—"Dittrich has shewn that after

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inveterate syphilis, the liver frequently presents a cicatriform tissue on the surface, which may extend deeply into the parenchyma. We have also noticed irregular scattered nodules, consisting, like the cicatriform contracted parts, of connective tissue. In the neighbourhood of these fibroid nodules, where the hepatic substance has already lost its normal texture, irregular clotted masses in which no further organization has been set up, may be observed." "The most remarkable distinction, therefore, between the granular liver, and that affected as above in cases of syphilis, consists mainly in the circumstance, that in the former the new formation appears in a diffuse, and in the latter, in a concrete form; that is to say, is more limited to isolated portions of the hepatic parenchyma. The process followed in the development of the new formation is of course the same in both; but whether syphilis alone produces the concrete form may perhaps admit of considerable doubt."

It is right with Wedl to partake of this doubt, although I do so but in a slight degree, seeing that the present specimen so closely resembles the above description given by Dittrich, and from the circumstance that I have already met with similar appearances in those who have died of syphilis, during my investigations of lardaceous disease which so often occurs in the same cases. Unfortunately I have not preserved these preparations to compare with the present one. It has also been stated that the same affection is found in the syphilitic fœtus; this I have not yet observed, although I have met with the general peritonitis, which various authors have described, and which sometimes form adhesions between the diaphragm and liver, with a considerable thickening of the capsule of the latter.

That these fibrous nodules in the liver are the result of syphilis, has a strong probability in the fact that similar fibrous deposits have already been observed occurring in the muscles, tongue, and other parts of the body of patients infected with this malady, as well as fibrous changes of the viscera themselves, as seen in the testes of the present case.

Dr. Wilks, 16*th of December*, 1856.

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DESCRIPTION OF PLATE III.

Figures 1 and 2 represent Portions of Liver, illustrative of Dr. Wilks's case of Syphilitic Disease of that Organ, p. 240.

Figure 3 illustrates Mr. Wood's Remarks on a case of Retention of the Testicle within the Abdomen, p. 265.

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38. *Scirrhus of the Gall-Bladder.*

The subject of this disease, a female, æt. 28, had always enjoyed good health up to a period of about four months before her death. She was then seized with vomiting and pain about a quarter of an hour after taking food. Occasionally she brought up small quantities of blood. Gradually becoming worse, she entered St. Mary's Hospital about six weeks before her death. She was then intensely jaundiced; the pain and vomiting continued, but with occasional remissions; a hard swelling was felt near the pyloric end of the stomach, which led to the idea of the disease being cancer of the pylorus; the stools never contained the slightest trace of bile. Under the symptoms she gradually sunk, exhausted.

After death the stomach was found much distended with a darkish, coffee-ground-coloured fluid; this viscus reached quite down to the pubes. The gall-bladder was converted into a hard scirrhus mass, the disease having evidently commenced in the tissues of the viscus; it had, at one or two points, thrown out processes into the liver. The section of the gall-bladder disclosed a contracted cavity, filled with gall-stones; the duct was quite impervious. The whole of the tumour was about the size and shape of a large pear. The tumour pressed upon, and adhered to, the anterior wall of the first part of the duodenum, but the pylorus and inner coats of the duodenum were perfectly healthy. All the tissues were deeply tinged with bile.

No other organ of the body was affected. But there was a considerable quantity of cancerous infiltrations beneath different portions of the peritoneum, particularly in the omentum, and around the rectum and caput cæci; there also were a few similar yellow cancerous masses beneath the diaphragmatic surface of the pleura, opposite to the base of the liver.

Cancer of the gall-bladder, as a primitive disease, is rare. In this case, it gave rise to symptoms exactly simulating those of cancer of the pylorus. By pressure upon the duodenum it obstructed the passage of the food from the stomach into the intestines; and, by interfering with the return of the blood from the stomach, gave occasion to the gastric hæmorrhage.

Dr. Markham, *20th of January*, 1857.

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39. *Cancer of the Liver and Mesentery.*

A female, æt. 62, hitherto healthy and stout, and the mother of a large family, began to suffer from pain and vomiting in September last. The medical gentleman whom she consulted found that her liver was considerably enlarged, and diagnosed a malignant affection of this organ. About six weeks before her death, Dr. Brinton saw the patient, and found that the liver reached considerably beyond its normal limits upwards, and still more downwards, where its lower edge had a hard nodulated feel, and occupied a line nearly on a level with the umbilicus. About one inch to the right of, and below, the umbilicus, there was a second tumour, about the size of a small orange, which faded away as it was traced upwards and towards the left side. This tumour was almost immoveable, and appeared to be separated by a distinct interval from the enlarged liver, and from the tympanitic cardiac end of the stomach. The pain was referred to the epigastrium and right hypochondrium, being most severe in the latter situation. It was increased by the ingestion of food. It was often connected with severe deep-seated pain in the right shoulder. The vomiting was also chiefly provoked by eating. There was no evidence of any discharge of blood ever having occurred in the stools or vomits; and the latter, when examined, seemed to consist exclusively of food, bile, and saliva. The appetite was bad; the strength failing rapidly; the skin and conjunctiva suggested a tinge of jaundice. Beyond this, however, there was no appearance of cachexia. There was no cancer in the family history.

Under these circumstances Dr. Brinton diagnosed cancer of the liver, with superficial inflammation of this gland; possibly, but not probably, secondary to similar disease of the stomach.

By suitable diet and remedies the vomiting was somewhat lessened, and the pain alleviated. She died, of increasing exhaustion, on the 25th of January.

On examining the still corpulent body, the liver was found greatly enlarged by cancerous deposit, which had reached the surface, and given rise to much adhesive peritonitis. The lower

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tumour consisted of mesentery similarly affected. The stomach was healthy.

The deposit had the microscopic characters (but not the external appearance) of incipient colloid. The differentiation of the cells and fibres was so complete, that the areolæ almost appeared to be bounded by a basement membrane enclosing the cell-mass. In the liver, the deposit had caused the isolation and degeneration of portions of hepatic substance. In the mesentery, it was mixed with a quantity of adipose tissue, quite disproportionate to the amount found in the healthier parts of this peritoneal fold.

Dr. Brinton, *3rd of February*, 1857.

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40. *Cystic Disease of the Liver.*

F. S. A., æt. 45, of a fair complexion, nervous temperament, and health not very robust, whilst in the country, the 12th of September, 1846, caught a cold, which was ushered in with violent pain across the epigastric region. A medical man was sent for, and he prescribed, but at the same time advised the patient to return home; as from the symptoms, he believed he was suffering from an attack of icterus-hepaticus.

On his arrival I found him in great pain, without vomiting, a slight yellow tinge being perceptible over the skin. I came to the conclusion that gall-stones were obstructing the duct; the next day the skin deepened in colour, the fæces were colourless, and urine of a very deep saffron. All these symptoms gradually yielded to the remedies employed, and in about four weeks he was sufficiently restored so as to proceed once more to the country.

On the 9th of February, 1857, the former symptoms returned, but not with the same severity, and more readily yielding to the remedies, he was able to resume his ordinary occupation in about a fortnight.

A good deal of debility and loss of appetite followed this attack; I therefore recommended him to try country air once more. He did so, but the weather proving unfavourable, he could only be induced to remain away eight days, and on his journey home he caught cold, and I was again summoned to see

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him on the 25th of March. He was then suffering from sickness accompanied with considerable pain, which I found was the precursor of another attack of the former disease.

On the second day, the skin was of a deep yellow colour, the urine loaded with bile, the stools nearly white. Upon making an examination over the seat of the pain, I found, upon percussion, considerable dulness below the false ribs, which with much convexity and an apparent hardened condition of the liver, great prostration of strength, and no abatement of the other symptoms, at the end of a week, induced me to recommend a second opinion to be taken upon his case, and Dr. Hyde Salter was called in. There was from time to time considerable variation in the completeness of the biliary obstruction, for although the urine was always full of bile, and the stain of the skin deep, there was often some bile in the motions; especially after the administration of a purgative. We inferred therefore that the source of biliary obstruction, though persistent, was not complete.

He complained for a few days of pain, or rather a sense of uneasiness over the liver, which was increased by pressure, but this subsided, whilst the extent of the dulness increased. At this time a slight undue prominence of the superficial veins of the epigastric region was first noticed, and shewed that the source of the jaundice, was exercising pressure on the inferior cava. The dulness of the right hypochondriac, and the epigastric region, was now complete, the dulness extending from the level of the nipple and lower parts of the sternum, to near the umbilicus, and a parallel line extending to the right.

The course of the symptoms from this time was as follows:— Increasing conspicuousness of the superficial veins, œdema beginning at the feet, and extending up the thighs, scrotum, loins, and abdominal parietes, so increased at last as to make the patient quite helpless, constituting the principle source of suffering, and which with occasional rigors, greatly exhausted him. Just towards the last, the hardness of the dull region below the margin of the right false ribs, was exchanged for a sense of fluid, there being a circumscribed fluctuation, and the finger, when pushed forcibly, meeting at first with a soft yielding, and then striking something hard below, giving the

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idea of a harder tumour below, covered with a stratum of fluid, and this the *post-mortem* examination shewed was the case.

Two days before death, fluid was detected in the peritoneal cavity, but only in a very small quantity; it was rather remarkable that there should have been throughout the case, at least with the exception of the first two or three days, an absence of pain, tenderness, and vomiting, or any derangement of digestion, and until the last, of ascites.

The condition that all the signs pointed to, was enormous enlargement of liver, biliary obstruction and pressure on the inferior cava, but no pressure on the portal vein or alimentary canal. He was taking a full amount of nourishment up to the time of his death, which was preceded by a severe and very distressing attack of dyspnœa on the 30th of April. This lasted up to within an hour of his death, when he became perfectly calm, dying soon after twelve o'clock the same night, and retaining, to the last, full possession of his faculties.

Post-mortem examination.—On opening the body fourteen hours after death, about a gallon of deeply coloured yellow fluid escaped; the liver was then seen to occupy the whole epigastric and right hypochondriac region. The transverse colon, lying across the umbilical region, enormously distended, explained the resonant prominence in that situation during life. The heart and lungs were completely pushed up out of place, and looked very small, the pericardium being deeply stained with bile. The convex surface of the liver was very mottled and irregular, and was firmly adherent to the diaphragm, which offered some impediment to its removal. When placed in the scales it weighed eight and a half pounds. The right lobe was occupied by a largely distended hydatid cyst, from which flowed, on cutting into it, a quantity of a peculiarly gelatinous material, of a pale amber colour, the consistence of thick gruel, and having a very offensive odour. This was followed by a more opaque and fluid matter, which looked like, and proved to be pus. This discharge left a large cavity, of which the small amount of liver structure that remained formed the shell. The matter thus liberated, when examined under the microscope, gave an abundance of hydatid walls of all sizes, from the one-tenth to the one-hundredth of an inch, with here and

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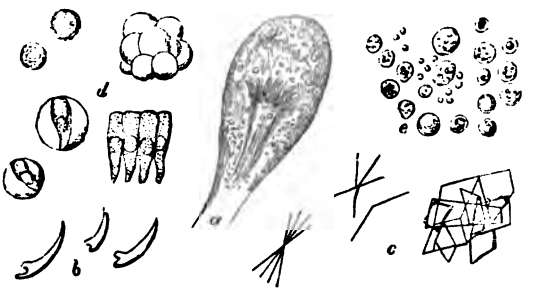
there echinococci and their hooklets, some needle-shaped crystals, fatty matters and cholestearine, with epithelium scales represented in the drawing, Fig. 10. The cyst had completely obliterated

Fig. 10.



a. Cyst with echinococcus.
b. Single hooklets.
c. Crystals distributed throughout the contents.
d. Cylindrical epithelium; some enclosed in a structureless membrane.
e. Puro-mucous corpuscles outside the cyst-wall.
Magnified 200 diameters.

the gall-duct, and, in the gall-bladder, four gall-stones were found, with some colourless fluid made up of cylindrical epithelium, most of which was enclosed in structureless spherical globules.

The left lobe of the liver was much changed in its character, being a softened mass, filled up with inspissated bile. The heart was small, readily breaking down under the fingers, and was in a state of fatty degeneration. As might have been anticipated, the kidneys were congested, and the whole viscera and tissues more or less stained with biliary colouring matter.

Mr. Jabez Hogg, 19*th of May*, 1857.

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V.—DISEASES, ETC., OF THE GENITO-URINARY ORGANS.

1. *Uterine Cysts.*

The patient, æt. 22, had been married five years, had had two children, and one miscarriage at the fourth month, between the births. She thought she was pregnant, and at the fourth month, owing to her increased size and having morning sickness. The catamenia had passed two or three times since her supposed pregnancy. On the 8th of July she expelled, with regular pains, several masses of watery cysts mingled with coagula, about one pint in all. The cysts were of various sizes, from a small walnut, to a grain of sand, some globular, some pyriform, and some cylindrical, hanging from each other by thin pedicles, or connected together by several filamentous attachments. There was a thick kind of basic membrane by which they were attached to the uterus, which varied in thickness, being in parts so thin as to admit of the cysts being seen through it. It was about seven inches square and probably lined the whole uterus as there was no appearance of placenta or membranes.

The cysts were formed of two layers of membranes, the outer pretty smooth, but exhibiting the markings of nucleated cells, which, embedded in the inner coat, or between them, projected through the outer one. The fluid contained in the cysts was slightly albuminous, and contained no cells; but where the cysts were torn from each other, masses of nucleated cells seemed to exude, and were carried away in the fluid. Some of the very minute cysts consisted of a few cells surrounded by a membrane like the placental villi. No blood-vessels were traceable either between the coats of the cysts, or along the pedicles. A coloured discharge, with occasional clots, has continued to the present time.

Dr. Ogier Ward, 21*st of October*, 1856.

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2. *Ovum Aborted between the Second and Third Month.*

The patient, had usually had abortions alternating with

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births, seven in all, but the two last conceptions had both aborted at about a year's interval, and all since the first between the second and third month. The present abortion seemed to be brought on by ill-treatment. The ovum closely resembled, in size and in the development of the fœtus, that represented as being between the second and third months in Dr. Hunter's Plates, Pl. xxxiii, Figs. 1 and 2.

The two layers of the decidua were generally, but not universally, adherent, and there was no prolongation of the decidua vera into the cervix, but the ovum terminated in a smooth rounded extremity, the whole having the shape of a flattened pear. At the angle of junction of the decidua, there was a small deposit of recent lymph or fibrine. In one spot the decidua reflexa was removed from the chorion, and in another, both these membranes were absent, so that the amnion was laid bare over a space of three quarters of an inch square, through which the fœtus was visible.

The uterine decidua formed a loose kind of case over the placenta, and the greater part of the ovum to which it generally adhered; and the placental tufts, therefore, did not penetrate through it to the uterine surface.

The ovum having been laid open, the limpid liquor amnii flowed out, and the fœtus appeared suspended by the cord, and enveloped in a fine transparent loose membrane, apparently a reflexion from the amnion investing the cord.

Below the fœtus, in the direction of the cord, was a small, triangular, white, flattened cyst, about a line in diameter, lying beneath the chorion, and containing a pasty substance that effervesced and dissolved in dilute nitric acid. A layer of dark coagulum could be seen through the chorion almost entirely surrounding the ovum, between the amnion and chorion, except where the opening was made into the ovum.

Dr. Ramsbotham has remarked, in ova of ten or twelve weeks, an effusion of blood between the layers of the decidua, and he refers also to a case described by Dr. Lee, who found a red coloured fluid in this situation, and therefore considers this a normal condition. But in this specimen the effused blood was between the chorion and the decidua reflexa, if it were not

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between the chorion and the amnion, and there is none between the deciduæ. I therefore consider this effusion to be morbid, and the probable cause of the death of the fœtus, and the consequent abortion; as it seemed to extend under the chorion beyond the insertion of the cord into the placenta. The placental tufts and villi appeared to contain no blood, as they were of the same yellowish tint as the portion of fibrine above mentioned, and no vessels were visible in them, even with a high magnifying power.

The structure of the tufts was peculiar; instead of forming cylindrical bodies, studded with villi as in the mature placenta, they resembled, on a minute scale, the uterine cysts last described, except that the dilated portions were cylindrical and not globular. From this appearance it seems to me to be highly probable that the uterine cysts are merely an exaggeration of the placenta in the early months of pregnancy.

Dr. Ogier Ward, *21st of October*, 1856.

Report on this specimen.—This specimen consisted of the major portion of the contents of the uterus expelled in an abortion. The entire mass, with the membranes, was about the size of a hen's egg. The principal interest of the specimen arose from its being an example of the cystic affection of the chorion in an early stage. When, however, the specimen was submitted to examination, it was too much decomposed to be of value for minute examination. Mr. Sibley agreed with Dr. Ward as to the mode in which the cysts had been developed, that is, by the gradual distention of the cells of the villi with serous fluid, in the manner described by Mettenheimer* and Wedl.†

Mr. S. W. Sibley, *4th of November*, 1856.

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3. *Cancer of the Os Uteri twice removed by Excision; the first Specimen being Medullary; the second Ciliated Epithelial Cancer.*

The patient, in this case, was a stout leuco-phlegmatic woman, æt. 52, residing at Woolwich. The first operation was per-

* Mr. Paget's "Lectures on Surgical Pathology," vol. ii.

† "Pathological Histology," Syden. Soc. Edit.

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formed early in May, 1856, she having then suffered from symptoms of the disease for nine months. The whole os uteri was involved in ulceration, and, from the anterior lip, there grew a fungating mass of cancer. Repeated hæmorrhages had occurred, but the woman was not yet reduced very low, and, as the uterus was quite moveable, and careful examination failed to detect any glandular or other secondary disease, it was determined to remove the part by excision. This was done, and, although the hæmorrhage was rather sharp at the time, yet the woman made a good recovery, and got entirely rid of the pain, discharge, &c., from which she had previously suffered.

Description of the first specimen shewn to the Society:—It consists of the whole anterior lip, and part of the front of the cervix, and of a thin slice of the posterior lip. The latter is concealed by the mass of soft fungating granulations, which grow from the former, and which present an almost round ulcerated surface, the size of a half-crown. The tissues of the uterus exposed in the section are quite healthy, and the line of circumscription of the cancerous deposit is well defined. The posterior lip is healthy, and had been so much displaced backwards by the growth, that but a very thin slice has been removed. The disease presents all the usual characters of soft cancer. Its section exudes juice plentifully, and, in the latter, are seen cells of various sizes and shapes, many of them very large, and containing from one to three distinct nuclei, with large notched-looking nucleoli. No epithelial cells were noticed, nor any arrangement of cells in the nested manner characteristic of epithelial cancer.

It should be stated, that there was no deep eating away of the uterine tissue in this instance, all the ulcerated part being occupied by prominent granulations, and that the border, where the cancer ended, was not much indurated. The patient having enjoyed good health and entire immunity from uterine symptoms for five months, consulted Mr. Hutchinson again in October, stating, that she had, for a week or two past, experienced pricking pain in the part exactly like that which she had before the operation. She was now stout, and of good colour. Vaginal examination with the finger did not detect anything, the puckered cicatrix

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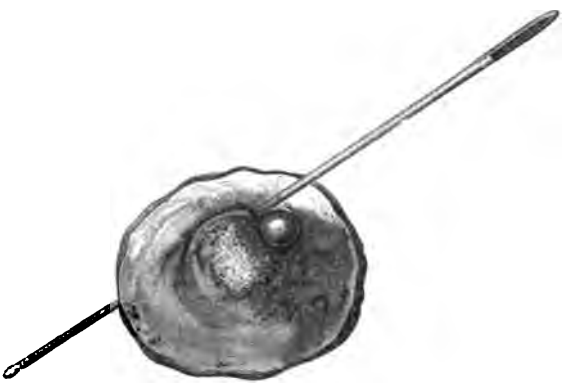
of the excision feeling quite sound. The remaining part of the posterior lip was felt as a low ridge, and, in other parts, the os was marked as a depression in the vaginal wall. On using the speculum, there was easily seen, just within the cavity of the cervix, and growing from its posterior surface, a florid mass about the size of a small hazel-nut, evidently of cancerous nature. It was not ulcerated, but was covered with a very delicate membrane, and there was a narrow belt of abrasion around its base. This examination confirming the patient's own impression as to the return of the disease, she was very desirous again to have it removed. On account of the bleeding which had attended the former operation, Mr. Hutchinson advised her to come into the Hospital for the second one, and she was accordingly admitted into the Metropolitan Free Hospital.

The second excision was performed on the 18th of October.

Fig. 11.



Front aspect of the parts Excised in the second Operation.

The patient being fully under the influence of chloroform, was placed in the lithotomy position, and the cervix uteri having been seized by a large vulsullum, was gently dragged down to the os externum. By means of a large pair of curved sharp pointed scissors, made to cut upwards, a portion of the uterine cervix, of somewhat conical shape, and including, at the lower part, its

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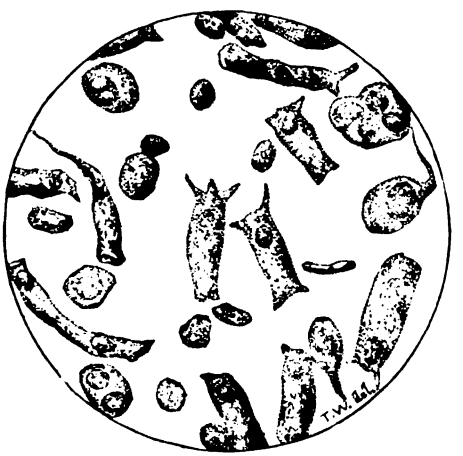
entire thickness, was removed, without endangering the peritoneum. This included the nodule of cancer, and a considerable thickness of healthy tissues surrounding it.

Description of the second specimen shewn to the Society, Nov. 4th :—Just within the cavity of the cervix is a nodular projection, about the size of a horse-bean, around the base of which the mucous membrane is superficially ulcerated. This nodule, when cut across, shews a whitish structure, from which juice may be obtained. Placed under the microscope, (Fig. 12) the juice shews abundant elongated mono-nucleated cells, like those of columnar epithelium, and many of these possess ill-formed cilia. In some, several cilia appear to have united together, thus giving a sort of serrate jagging to the crown of the cell, instead of the delicate prolongations of fimbriæ seen on well formed ones. Many of the cells are mis-shapen and withered, others are large and flattened, and some contain two, three, or even four nuclei. Fragments, in which

FIG. 12.



Microscopical appearance of the juice from the second specimen.

cells adherent together by their sides, and overlying each other, somewhat in the manner of the cells composing the walls of the

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nested bodies of epithelial cancer were also seen, but in none was the appearance of an entire nest produced. Still the similarity between the arrangement of the cells to that observed in the common epithelial cancers was close, with the difference that here the cells were columnar and ciliated, and in those of the tesselated variety. Very few cells like those seen in the former specimen were discovered, but there were a considerable number of free nuclei. That the epithelial structure prevailed throughout the entire nodule, and at a distance of at least a quarter of an inch from its free surface was quite certain.

Mr. Hutchinson stated, that from the frequency of cancers possessing the tesselated epithelial structure on parts covered by that form of epithelium, it might, *a priori*, have been supposed that the ciliated epithelial membranes should be liable to a like type of cancer. He was not aware, however, of any observation of the actual occurrence of this form prior to the present. The circumstance of the form of cancer differing so markedly in character on the second from the first occasion, is also another feature of much interest in the case. With regard to its surgery, the patient being still in good health, the lesson of the case is strongly in favour of the practice of excising cancer of the os uteri when accessible.

Mr. Jonathan Hutchinson, *4th of November*, 1856.

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4. *Proliferous Ovarian Cyst, associated with Medullary Cancer and Melanosis in the Liver, one Supra-renal capsule and lymphatic glands.*

The history of the case is briefly as follows:—J. A., æt. 33, married twelve years, without family and never pregnant. Nine years ago she first experienced violent pain at the catamenial period, followed afterwards by the presence of a tumour in the left side of the belly, which could be felt to be of the size of a fœtal head. Its origin was, however, attributed to lifting a heavy weight before marriage, followed immediately after by severe pain in the loins and left hypogastric region. The tumour steadily increased up to the present time, although at one period,

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it partially disappeared; its rate of growth has been more rapid for the last four years. When first under my care, two years and a half ago, she measured thirty-five and a half inches round the abdomen, and this has continued the average dimension to the time of death. The catamenia have been perfectly regular at all times. None of her sisters or blood relations are affected with the same complaint; two of her sisters are the mothers of families. Two years ago last August, a distinct brownish discoloration was visible about the abdomen, especially marked below the navel. The chest was also very brown, over the sternum particularly. No importance was attached to this at the time. She suffered all the inconveniences, and general interruption of various important functions, arising from the mere presence of the tumour; the legs were at times purple and mottled from venous congestion; she was frequently low spirited and hysterical; suffered agonizing pain in the vagina and external parts a few weeks before death, together with excruciating pain in the loins; and finally the performance of the most common functions of life became so much interfered with, as to produce inanition, prostration, and extreme debility; death occurred on the 10th of November.

Post-mortem examination, seventeen hours after death.—There was much general emaciation, but no rigor mortis present. The lower three quarters of the abdomen was remarkably prominent, and resembled the pregnant state; the prominence measured seventeen and a half inches from the ensiform cartilage to the pubis, and round the loins, over the highest point of the tumour, the circumference was thirty-five inches. On cutting through the linea alba over the tumour, it was found to be very thin, and the great bulk of the tumour immediately presented itself to view, very slightly adherent by cellular tissue. At its posterior part the adhesions were somewhat thicker and stronger; at its lower part, corresponding to the inner surfaces of both ilia and the margins of the pelvis, they partook of the character of thick, strong, fibrous bands, which kept the growth very strongly in its natural position. By very great efforts, and a good deal of dissection, the pelvic portion of the tumour was removed, with the bladder attached to it, the rectum and anus,

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a portion of the vagina, and the uterine organs, all much adherent to one enother, and scarcely distinguishable from their surrounding parts, especially the uterine organs. The great bulk of the tumour was globular; it extended into the cavity of the true pelvis, pressed there in every direction, and so completely filled it that the finger could not be passed between the promontory of the sacrum and its side, thus greatly compressing the rectum, which was empty, and so preventing the passage of fæces during life. The bowel passed upwards through the left side of the pelvic portion and pursued its course to the colon, the sigmoid flexure of which was obliterated. All the bowels were displaced upwards, the alimentary canal was normal throughout its entire extent, but the ileum and colon were, however, filled with hardened scybala, and the stomach contained a little grumous fluid. The bladder was empty, and situated on the anterior and lower part of the tumour; it adhered to its surface, slanting off towards the right side, and was elevated above its natural position. The left ureter and kidney were healthy, whilst the right ureter which coursed over its posterior and lateral border, was much dilated in size, as was the kidney, which presented a distinct sacculated condition, weighing less than half an ounce. Its pelvis and the dilated ureter were filled with urine. The supra-renal capsule of this kidney was enlarged, and formed a tumour of a brown colour, the size of a goose's egg, soft in structure, and on section resembled true cancer;* the left supra-renal capsule on the other hand was healthy. The spleen and pancreas were healthy. The liver was greatly enlarged, its left lobe extending across to the left side; the convex surface of its right lobe was firmly adherent to the diaphragm, its surface being irregular in various parts from the presence of numerous cancerous patches, varying from the size of a pea to a shilling, and existing also in clusters. The larger were quite white, and found to be circular on section, whilst many of the smaller were red in colour. Many of these were found throughout the substance of the organ, but its structure generally was soft and friable, natural in colour and large grained. The gall-

* This supra-renal capsule was reported upon, *vide* the Diseases of the Supra-renal Capsules.

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bladder was filled with bile, and normal. Most of the viscera described were displaced upwards, especially the thoracic; both lungs were healthy in structure, covered all over with carbonaceous deposits, but emphysematous to a marked degree, the right especially. No pleuritic adhesions were present, nor effusion of serum, either into the chest or abdomen; the pericardium contained about two ounces. The heart, although small and soft, was quite healthy. The bronchial and deep lumbar glands were much enlarged, some of the latter to the size and shape of a small kidney potatoe, and the former to that of a small walnut, and many of each were quite black in colour, and gelatinous on section, resembling malenosis. All were affected with medullary cancer as shewn by the microscope, and in those which were black, the same form of cancer was present, infiltrated with granules of black pigment.

Urine.—The quantity obtained from the ureter and pelvis of the right kidney, was twelve drachms, of a muddy-brown colour, and peculiar butyric odour; specific gravity 1·016; alkaline. Albumen was thrown down by nitric acid and heat; no sugar was present. On standing awhile, a gelatinous precipitate of a pinkish colour subsided, the fluid above being of a clear, dark-brown. The deposit consisted principally of broken up epithelial scales from the mucous membrane of the ureter and pelvis of the kidney, with a little lithate of ammonia. On standing two or three days a distinct pellicle formed on the surface of the fluid like that on mutton broth, which proved to be fat and crystals of lithate of soda.

Description of the tumour.—It is of a globular, somewhat pyriform shape, being divided into two portions, a superior and inferior, the former existing within the cavity of the abdomen, whilst the latter filled completely the true pelvis, the entire weight being twenty pounds, ten ounces; in its dimensions, it is thirty inches in its lateral circumference, and forty-one in its longitudinal ditto, being twenty-seven and a half longitudinally from the commencement of the pelvic portion at the pubis, upwards, backwards and downwards to the promontory of the sacrum, whilst the circumference of the pelvic portion is thirteen inches. The surface of the superior portion is coursed all over with veins and

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small blood-vessels, and is surrounded with bands of fibrous tissue; its walls are thin and fluctuating in some parts, and firmer at others, more especially towards the left side inferiorly, where can be felt what seems to be the body of the uterus, apparently of the size of that organ on the birth of a four months' child. It is of a bluish and greenish-blue colour over the greater part of its extent, over others, reddish and very vascular. Coursing over the right lateral and posterior border of the globular portion of the tumour, is seen the ureter of the right kidney, very much dilated upwards, towards that organ, varying from three quarters of an inch to upwards of an inch and a half, close to the kidney itself, and filled with urine. The pelvic portion of the tumour is of a deep crimson colour in several places, and feels as if containing fluid in its interior; it is highly vascular. The vagina runs in an oblique direction upwards towards the left side in front of the tumour, is of its natural length, narrowed at its termination, and on slitting it up the os uteri is seen in the form of a tubercle, which admitted the passage of a probe; the cervix here could not be seen; on incising the os, so as to expose the interior of the uterus, the cervix is found to be one inch and three quarters in length, and very vascular. The length of the uterine canal is two inches and a half, not exceeding half an inch at any part in width. The openings of the Fallopian tubes are impervious to the finest probe. The uterus was opened to display its interior, from the back part of its fundus, which presented itself anteriorly towards the left side on the surface of the lower part of the tumour, having been completely turned over towards the right side in its position, thus throwing as it were the ovarian tumour, which appeared to spring from the left ovary, forwards and to the right side, and incorporating the whole of the anterior wall of the uterus itself, which seemed to be completely embedded in the tumour. The right ovary and Fallopian tube can be traced, but the ovary is enlarged into a mass the size of a hen's egg, and consists wholly of medullary cancer. The rectum pursues a similar course to the vagina, but does not lay immediately beneath it, excepting near the anus. It passes through the great bulk of the pelvic portion of the tumour, and is quite free from disease. This portion of the tumour, on section,

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in various parts, is seen to consist of blood, partly fluid and partly coagulated; this was especially the case in three distinct portions, the largest the size of a walnut, where it possessed a deep, reddish-brown or black colour; the remainder of the pelvic part of the tumour being well-marked medullary cancer, projects in the form of a fungous-looking mass, into the base of the abdominal tumour, which proves to be a large cyst. The whole of the pelvic portion thus affected with soft cancer, has been comparatively of quite recent growth, and thus accounts for the severe pain complained of a few weeks before death, and at the same time for the difficult passage of fæculent matter, the rectum being completely surrounded by the cancerous disease. The histological characters of the blood just described were—the corpuscles all shrivelled up, and mixed with cancer cells of various shapes filled with nuclei; and some granular matter. On adding water, the corpuscles swelled out, then became transparent and indistinct. Some of the cancer cells were filled with nuclei, and in some of the latter could be discerned nucleoli. The abdominal portion of the tumour proves to be a large cyst, filled with fluid, on emptying which the lining membrane is shrivelled up like the folds of the stomach. At its lower part is seen the fungous surface of the projecting part of the true pelvic tumour, four inches in diameter, and of a convex shape, distinctly cancerous. There were several other smaller fungous projections into the cyst, springing from its walls, which were of the same nature, the largest the size of a hickory-nut. Within the walls of the cyst, at its upper and left side, was developed another cyst, somewhat flattened, projecting inwards, a little over two inches, being four inches and a half in its extreme, and three inches in its short diameter. This cyst possessed a distinct capsule, and contained several other cysts, developed within its own walls, besides twelve drachms of a very thick viscid gelatinous substance of a streaked, fawnish-grey colour, but not uniform. The same kind of fluid was present in one of the cysts, the size of a robin's egg, whilst a thick, creamy-fluid, of a yellowish-white colour, was present in a cyst the size of a pigeon's egg. The contents of these are separately described below, according to their size, commencing with the parent cyst, and continued to the smallest which yielded any fluid contents, of which there were several of the size of peas and beans, and

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even much smaller. The general structure of the parent cyst consisted of fibrous tissue, which formed a middle wall between its external peritoneal covering, and internal pseudo-mucous lining. The smaller cysts were developed between the lining membrane and fibrous coat of this large one. Their general structure was also white fibrous tissue. Each one of the cysts appeared to have two coats, and was distinct from the other. The lining membrane of all consisted of hexagonal pavement epithelium.

No 1.—Parent Cyst.—Contained eleven pints and fifteen ounces of an opaque, dark-brown, or chocolate-coloured fluid, being very viscid, and of oily consistence, not unlike dark grumous blood; it flowed very slowly through the canula. Its specific gravity was 1·042. It felt unctuous between the fingers, and tenacious. On boiling, it formed a thick pultaceous mass, which, in cooling, became quite solid and firm. It contained five and a half per cent. of fibrine, and twenty-one per cent. of albumen, the former being equivalent to twenty-six and a half, and the latter one hundred grains to the ounce; its colour being due to the presence of hæmatine with globuline. Several ounces were evaporated to dryness, then burnt in a crucible, the ashes being acted upon by hydrochloric acid, in which iron was then detected in very appreciable quantity. This dried substance, before being burnt, resembled the dried coagula of blood, possessing, however, more of a black than a dark-red colour. No gelatine, or chondrine, or sugar, were present.

Microscopic Characters.—A few isolated fat vesicles, fat globules, fat molecules, free and in clusters; compound granular corpuscles; altered blood discs, many of them preserving their circular form; *debris* of lining membrane of the cyst, of blood globules and fat cells. A few plates of cholestearine. No appreciable difference on adding acetic acid.

No. 2.—Twelve drachms of a fawn and drab, thick, viscid mucous fluid, very ropy, oily feel. It contained a large proportion of gelatine, a moderate quantity of chondrine, and a little albumen.

Microscopic Characters.—Fat vesicles of various shapes and sizes, fat cells, granules, and star-like masses of fat, not in vesicles, besides *debris* of fat cells. A number of fusiform cells were rendered

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distinct by adding liquor potassæ; they were evidently from the lining membrane of the cyst.

No. 3.—Cyst the size of a pigeon's egg. Cream-like fluid, yellowish-white colour, of a greasy and slippery feel. Contains albumen in small quantity, less gelatine than Nos. 2 and 4, and more chondrine. Chlorides, sulphates, and a very appreciable amount of phosphates were present.

Microscopic Characters.—Fat cells, filled with fat granules; numerous broken up and irregular fat cells; clusters of smaller cells, fat crystals, and granular matter. Very few fat vesicles.

No. 4.—Cyst the size of a robin's egg. A very tenacious greyish-white, viscid, and ropy gelatinous fluid, a little lighter in colour than No. 2. Contained no albumen, but gelatine and chondrine; the first in less, and the second in greater proportion than in No. 2.

Microscopic Characters.—Few flat fibres, small irregular shaped cells, free from nuclei, many of which were broken up, and a few isolated fat vesicles.

No. 5.—Size of a chestnut. Fluid of a dirty, opaque, drab colour, with myriads of fat cells and granules.

No. 6.—Size of an almond. A glairy, fawnish, gelatinous fluid, with *debris* of the lining membrane of the cyst, and a few isolated fat cells. Contained gelatine and chondrine.

No. 7.—Size of a filbert. A light brown, thick, creamy fluid, filled with fat cells, crystals, and globules, and a few transparent fibres. Contained chondrine.

No. 8.—Size of a small marble. A bread-coloured creamy fluid, with myriads of fat cells, and some needles of cholestearine.

No. 9.—Size of a marble. Clear albumino-gelatinous and viscid fluid, with large fat vesicles and plates of cholestearine; also a few fat cells, and beautiful fat crystals.

The contents of the other and smaller cysts were not dissimilar to the above. Dr. Gibb, *18th of November*, 1856.

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5. *Villous Growth from the Bladder.*

J. C. S., æt. 59, a shoemaker by occupation, was admitted to the

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Mary-le-bone Infirmary, under my care. Fourteen months previously he first experienced symptoms of urinary derangement, commencing with an attack of irritability of the bladder, without any very obvious cause. He suffered from this to a great extent, but did not apply for advice until five months ago, when he became a Hospital out-patient, and was sounded for stone, having recently passed blood for the first time. He soon became worse, was unable to attend, and was admitted under my care at the Mary-le-bone Infirmary, in September, 1856.

He then passed water on an average every fifteen minutes day and night, and it had a dark red tint, evidently from admixture of blood. The prostate was not perceptibly enlarged, as felt per rectum, but was tender on the left side. I sounded him, but found no stone, nor any difficulty in passing the cathether. Some sanious pus flowed through it.

The urine contained mucus, and much albumen, and was strongly alkaline. Much pus and triple phosphate, blood corpuscles, and large granular corpuscles, were seen. The patient was relieved by acids and bathing with daily hip-baths, and morphia; the blood disappeared under this treatment for a month or more, and never re-appeared in much quantity. He gradually grew weaker, passed more purulent urine, and died much emaciated on the 12th of November.

On opening the bladder, the walls of which were considerably thickened, a mass, about the size, and having very much the appearance of a large strawberry, was seen attached to the floor of the bladder, about midway between the orifice of the left ureter, and the base of the prostate. Near to it was the orifice of a large abscess, seated in the wall of the viscus. The neck of the bladder, as well as the tumour, was coated with phosphatic deposit; and the lining mucous membrane of the bladder was very rugose, thickened, and exhibited dark slate and crimson tints. On closely examining it, very minute elevations might be seen almost throughout its whole extent, not villous, but mammilated. On placing them under the microscope, they appeared to be elementary forms of the same disease as that especially developed in the tumour. The tumour appeared much larger when immersed in water, innumerable slender branches floating out in

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every direction. Portions of these under the microscope, shew it to be made up of soft, loosely aggregated filaments, similar to those of fine areolar tissue, with a very few small cells. Numerous elongated nuclei lay upon the filaments. The mass is pervaded by small blood-vessels throughout. This preparation corresponds very closely with the villous tumours, from the colon and the bladder exhibited by Mr. Sibley last Session, the main difference being the much smaller proportion of the cell to the fibrous elements. Mr. HENRY THOMPSON, *18th of November*, 1856.

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6. *Large Polypus of the Uterus, separating spontaneously.*

For permission to exhibit this specimen I am indebted to Mr. J. Hamerton, of Elland, Halifax. On the evening of the 15th of November last he was requested to attend a female, æt. 58, who had been married twenty years, and during that time had borne four living children, and had had five miscarriages. Fourteen years of the twenty she had been the subject of a tumour presenting in the vagina and gradually descending to the os externum. She consulted two medical gentlemen who gave it as their opinion that the case was prolapsus uteri, for which they recommended her to wear a pessary. The pessary gave her so much pain that she withdrew it, and substituted a bandage with pressure.

The tumour gradually increased in size; and the distressing hæmorrhage which frequently occurred, along with a constant leucorrhisal discharge, and an annoying and uncomfortable dragging weight so undermined her general health that she had all the signs of debility, with a jaundiced appearance of the countenance.

When her husband arrived at the house of Mr. Hamerton, he stated that "his wife had discharged her womb," and that it was entirely separated. On arrival, a large elongated tumour was found, weighing nearly a couple of pounds. It was nine inches and a half in length, and three and a half inches in diameter. It presented at its upper extremity the mark of attachment of its peduncle, and at its lower protruded extremity a transverse indentation very much resembling an os uteri. The patient was in an excited state, not knowing what the consequences might

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be from discharging so large a substance. She had rather copious hæmorrhage, with a weak, rapid, and fluttering pulse, to arrest which the ordinary remedies were had recourse to.

Vaginal discharge continued for about ten days after the separation of the tumour. It then disappeared; and since then the patient's health has been rapidly improving. The size of the tumour, the long period of its existence, and its spontaneous separation are worthy of remark in this case.

Her previous medical attendants, I am informed, never made any vaginal examination; but, had they done so, the curious resemblance of the protruded extremity to an os uteri would have rendered an incorrect diagnosis quite possible.

Dr. Sydney Jones, *2nd of December*, 1856.

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7. *Testicle retained in the Abdomen by adhesion to the Sigmoid Flexure of the Colon.*

This specimen was taken from the body of a man, aged between 40 and 50. The right testicle was in the scrotum, and double its natural size. The left side of the scrotum was empty, the testicle being found, on opening the belly, to be lying in the left iliac fossa between the sigmoid flexure of the colon, and the internal abdominal ring, Plate III., Fig. 3. It looked tolerably plump, but was only one-third its proper size. On the inner side of the gland was placed the epididymis, the globus major reaching above, and the minor below it. The latter passed for about half an inch through the internal abdominal ring. Connected with it in the usual manner, and also engaged in the orifice of the ring, was the vas deferens, of the normal calibre and appearance.

Passing from the globus major, at its junction with the testicle, to the mesenteric border of the sigmoid flexure of the colon above it, were three very distict transparent elevated bands of adhesion, of which the one placed most internal was the longest and strongest, as shewn in the Plate.

The spermatic vessels, rather smaller than usual, passed behind the adhesions to enter the testicle and epididymis. A pouch of peritoneum, like a hernial sac, extended through the inguinal canal, projecting about three-fourths of an inch outside the

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external ring. A slip of fascia, very like the cremaster muscle in appearance, passed from its attachment to Poupart's ligament, one portion going out of the external ring to be lost in the scrotum, and another directly over the cord to the conjoined tendon. On examining this with the microscope, however, no trace of muscular fibre could be found in it. The cremasteric branch of the epigastric artery was present, and fully of its normal size. The remains of the gubernaculum could be traced, but nothing more than white and yellow fibrous tissue and fat could be seen in it with the microscope. In many of the mesenteric glands were found chalky concretions like the *debris* of tubercle. No other adhesions were found in any part of the peritoneum.

These conditions seem to point out the history of the abnormal state as—local inflammation from mesenteric disease in fœtal life, or early infancy—formation of adhesions, and arrest of the descent of the gland at the utmost stretch of the adhesive bands. The testicle, the seminal tubuli of which seemed healthy, had been stunted in development because of its unfavourable position, and its seclusion from external stimuli, though probably able to secrete a partial amount of semen. The other testicle had adopted a sufficiently counterbalancing vicarious action. Mr. John Wood, 16*th of December*, 1856.

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8. *Diseased Prostate Gland.*

R. F., æt. 55, a carman, was admitted into the London Hospital, on the 11th of November, 1856, with symptoms which had raised some suspicion of the existence of stone in the bladder. He stated that he had been free from any disorder of the urinary organs until about five months ago, when, after violently exerting himself in lifting a heavy stone, he felt an urgent desire to micturate. Since then, the act had been attended with severe pain in the urethra and glans penis, but he had never passed any blood. Previous to this attack, he was accustomed to take beer and spirits, but he had since given up the use of alcoholic beverages. On his admittance, his face was observed to be somewhat flushed, and to have a pinched appearance. After injection

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of the bladder, I introduced a sound without difficulty, but did not succeed in finding a stone. The passage of the instrument was attended with pain, and was followed by slight bleeding. On examination per anum, I found the prostate enlarged, tender, indurated, and nodulated. His urine was clear, slightly ammoniacal, and free from albumen, specific gravity, 1·015. In a few days after his admission, he complained of suffering pain in the lumbar region. The difficulty in passing water increased, and the pain in the urethra during and after micturition became intense. On the 29th retention occurred. A catheter was passed without difficulty, and a pint and a half of turbid and very offensive urine removed; from this time he lost the power of voiding his urine. He continued to suffer pain, preferring sitting up in bed to the recumbent posture. He gradually got weaker, and into a typhoid condition, became comatose, and died on the 2nd of December.

Post-mortem examination.—The body was examined twenty-six hours after death, and the urinary organs were carefully removed. Both kidneys were much enlarged, and presented a mottled appearance, the tubular substance, on section of the organs, being congested, and the cortical closely studded with small white granules. Deposits of a similar character were also observed in the tubular substance. Numerous cysts of various sizes occupied the cortical substance. In the left kidney, there was one the size of a hen's egg. The appearances were those of old Bright's disease, with recent acute inflammation. The mucous membrane of the bladder was congested, and its muscular structure thickened. The prostate was enlarged, and its middle lobe prominent, and it was also much harder than natural. On section, its texture appeared semi-pellucid, and closely dotted with opaque yellow spots, from which there issued, on pressure, an abundant quantity of a thick homogeneous-looking juice. The thick juice was examined by Dr. Andrew Clark. Water rendered it turbid, and threw down an albuminous fluid. Under the microscope it exhibited:—First, masses of corpuscles corresponding in size and character to gland vesicles, except that they were interspersed with numerous compound granule cells. Second, gelatine-like masses of the same size as the former, of faint,

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yellowish colour, and structureless. Third, numerous free cells apparently corresponding to liberated gland cells. Fourth, numerous free nuclei. Fifth, groups of enlarged cells, each with a tumid vesicular nucleus; the outline of the cells being pyramidal, fusiform, and clavate, and the groups few. Sixth, nuclear fibres.

The state of the prostate, as ascertained by examination during life, and the appearances which it presented on section after death, led me to infer that the disease was scirrhus, but this conclusion was not confirmed by the microscopic examination.

Mr. Curling, *6th of January*, 1857.

Report on the above Specimen.

The prostate was little enlarged or altered in shape; it cuts with a tough and dull, rather than a cartilaginous or creaking section, but is evidently somewhat altered by maceration. Examined under the microscope, thin sections shew the usual muscular, fibrous, and glandular constituents of the prostatic substance, with all their ordinary distinctness of contrast and characteristic arrangement. Acetic acid brings out a large number of the nuclei of unstriped muscle, and elastic fibres of connective tissue, the various septa of the racemose glands or acini. These are, however, distended with an unusual quantity of their ordinary epithelium, and many of them contain large (one-tenth to one-twenty-fifth of an inch) ovoid masses of a protein compound, which dissolves readily in potash, but not at all in acetic acid. These masses consist of ten to twenty concentric laminæ, enclosing a central kernel of crystalline fat (margarine?) of a transparent or cellular appearance. Some are of a pinkish tint, as if coloured by hæmatine. Considering the moderate and uniform enlargement of the prostate generally, the absence of out-growth or deformity, the absence, not only of cancerous cell-growth, but even of all foreign tissues in its structure, and the perfect distinctness of its various elements in their normal proportion—we may confidently deny the cancerous nature of the specimen, and think that its appearance may be best summed up as an hypertrophy of the secreting organ, in

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which subsequent degenerative changes have taken place, thus exhibiting healthy gland-structure in one part, and in another a substance in which fatty and fibrinous materials are predominant.

Dr. Brinton and Dr. Wilks, *20th of January*, 1857.

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9. *Large Deposit of Softened Tubercle in the Interior of the Uterus.*

My friend, Mr. Joseph Allen, one of the Resident Medical Officers to the Liverpool Royal Infirmary, and a very zealous pathologist, sent me up for examination the specimens described below. They had been removed from the body of a girl, æt. 15, who had died in the Hospital of albumenuria, after a protracted illness. No uterine symptoms had been present during life, and it was believed that menstruation had never taken place.

At the *autopsy* the liver and kidneys were found to be extensively involved in fatty degeneration. Miliary tubercles were scattered through the lungs and deposited on the pleuræ, and in some dense bands of pleural false membrane were some crude masses of the same. The more interesting condition was, however, found in the uterine organs. The uterus itself was distended into a cavity which contained, perhaps, about two drachms of fluid resembling ill-formed pus, only more glairy and adhesive. At first sight its shape, from the distance of the Fallopian cornua, suggested the idea of its being bi-cornuate, the right side being, however, much the larger of the two. That this form was, however, merely the result of distension of the uterine body with fluid, there could be no doubt. Examined under the microscope, the fluid presented the elements of degenerate tubercle mixed with pus and mucus. A great majority of the cells were shrivelled and mis-shapen, and the quantity of oil globules and of granular matter was very great. There was no acute inflammation of the lining membrane of the uterus, or of its walls; but in parts the latter were congested, and a little softer than natural. The mucous membrane was, for the most part, pale, but here and there it presented a mottled condition. The cervix uteri was healthy, and the plicæ of its mucous lining beautifully distinct. Although, when the specimen

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reached me, its canal was laid open, and no evidence of any occlusion could be observed, yet there could be no doubt, from the distension of the uterine cavity above it, that the os internum had been closed during life. In the left Fallopian tube were three or four small masses of crude tubercle, from the size of a shot to that of a pea.

The interest of the specimen lies, first, in the rarity of tubercle being found in the uterine organs, and secondly in its exemplifying the deposit of that material on the free surface of a mucous membrane. There was no evidence of ulceration of the mucous membrane whatever, nor any deposit in the parenchyma of the organ. I was inclined to regard it as illustrating the exudation of tuberculous material on the free surface of the lining membrane, by which chronic inflammation, ending in the effusion of an admixture of pus had been caused. This view of the pathology of the specimen I am glad to be able to support by the authority of my friend Dr. Snow Beck, who was kind enough to make a careful examination of it. He writes, "The mucous membrane of the body appears intact, and there is undoubted tubercle deposited in it."

Mr. Hutchinson, 20*th of January*, 1857.

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10. *Large Fibrous Tumour within the Abdomen, supposed to be of the Right Ovary.*

The tumour was situated in and above the right iliac fossa; its weight was between six and seven pounds; its external layers were rough and calcified. On section, it presented a uniform surface, quite peculiar, of a bluish-flesh colour, very elastic to the touch, and feeling like india-rubber. It was adherent at numerous points to the intestine, omentum, and abdominal walls posteriorly. The adhesions were not inflammatory, but enclosing fresh accessions of vascular supply from neighbouring visceral branches. There was also a tumour in the body of the uterus, of the size of an orange; it occupied the left side of the pelvic cavity. The uterus was atrophied. The left ovary was twisted into the right ovarian region. The subject was about sixty years of age.

Mr. Nunn, 3*rd of February*, 1857.

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Report on the above Specimen.—The preparation referred to us consisted of two fibrous tumours — one nearly as large as an adult's head, the other somewhat smaller than the fist—connected with one another by a thickish band of fibroid tissue, attached to which was a small, but otherwise healthy cervix uteri. Only one ovary and one Fallopian tube were present; and these appeared to spring from the larger tumour, in the neighbourhood of its attachment to the fibroid band.

The larger tumour had something of an hour-glass form, and measured eight inches in length, by five or six inches in thickness. Its surface was tolerably uniform, but at the same time, studded with numerous small rugged projections, which evidently consisted of earthy matter. It had been extensively adherent to surrounding structures, and the appendix vermiformis and large portions of the great omentum were still attached to it. On section, it appeared to consist of two parts—a cortical, from half an inch to three-quarters of an inch in thickness, which had, for the most part, a buff-colour, and consisted of a greyish fibroid tissue, very thickly studded with yellowish masses of earthy matter—and a medullary which was dense and tough, had a dusky reddish hue, and appeared to consist of a mixture of greyish fibroid, with reddish fleshy-looking tissue, arranged, in an irregularly wavy and concentric manner. Although on a cursory glance the cortical and medullary portions appeared distinct from one another, they were really perfectly continuous; the difference between them being, so to speak, merely accidental, and dependant on the limitation of earthy degeneration almost exclusively to the periphery. Under the microscope, the tumour was found to consist essentially of fibroid tissue and organic muscular fibres. These elements varied in their proportions in different parts, so that, while some sections presented few muscular fibres, others consisted of little else. The muscular fibres were arranged in groups, which varied in size, but which were generally more or less cylindrical, and crossed one another in all directions. The individual fibres were cylindrical, pellucid, with definite margins, and between $\frac{1}{4000}$th and $\frac{1}{9000}$th of an inch in diameter. Earthy matter, in the form of minute spherules, was found sparingly among the fibres in the central parts of the

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tumour. In the periphery however, it was very abundant, and existed both under the form just mentioned, and as irregular masses of various sizes.

The smaller growth was irregular, and somewhat lobulated in form, and had been connected by adhesions with adjacent structures. It was close grained, tough, and whitish, and presented on section, that irregularly lobulated character, (due to the wavy and knotty arrangement of the fibres,) which is common in fibrous tumours of the uterus. Under the microscope, this, like the larger tumour, presented fibroid tissue and organic muscular fibres. The latter, however, were smaller, less distinct, and much more difficult to isolate.

The os and cervix uteri were small, but healthy in other respects. The canal of the latter was narrow, and ceased abruptly at the internal os. The only recognisable remnant of the fundus of the uterus, was the comparatively small quantity of fibroid-looking tissue, which, radiating from the top of the cervix, formed the band connecting the two tumours; but no uterine cavity could be detected. The entire length of the band was about four inches; that portion of it which might be called the pedicle of the small one, was about half an inch, and that which might be called the pedicle of the larger one, about two and a half inches in length.

The ovary that was present was of ordinary size, perfectly healthy, and connected with the large tumour close to its junction with its pedicle, by a ligament which appeared to be the ligament of the ovary. The single Fallopian tube had the usual length of that organ; its free extremity was fimbriated, and its opposite extremity, much attenuated, was connected with the same part of the larger tumour as the ligament of the ovary.

No trace of the other ovary and Fallopian tube could be discovered, but judging from the appearances presented by the preparation, there were several spots which might have given origin to them. They might have been connected with some part of the band, which represented the uterus, or they might have sprung from some part of the smaller tumour.

From the general appearance of the tumours, from their con-

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sistence, and the arrangement of their fibres, as well as from their microscopic structure, it is quite certain that both of them were (so called) fibrous tumours of the uterus; that they had originated in the uterus and not in any other organ; and hence that in process of growth, they had become pedunculated.

With regard to the smaller one, we presume that little difference of opinion can be entertained; there was nothing about it to suggest any other origin than that assigned by us. We think moreover, its structure, like that of fibrous tumours generally, was as nearly as possible identical with that of the healthy unimpregnated uterus. The larger one, though resembling this in every important particular, presented two or three points of difference which are worth consideration. In the first place, degeneration had commenced, and the degeneration instead of primarily affecting the central parts, or of invading the growth irregularly, was limited to the periphery; the cause of this unusual limitation is not very clear, but that it is not unprecedented is shewn by a preparation in St. Bartholomew's Hospital. In the second place, the muscular tissue was unusually well developed, and approached far more closely in all its characters to that of the impregnated, than to that of the virgin uterus. And in the third place, an ovary and a Fallopian tube appeared to spring from it; the cause of this anomalous arrangement is probably to be explained by its development; it seems pretty clear that the growth had originated in that portion of the uterine walls, which lies close to the attachment of the Fallopian tube and ovary of one side, that in process of growth it had gradually become pedunculated, carrying with it for its peduncle a portion of the uterine fibres, and separating with itself from the body of the uterus, the appendages, between which and the uterus it had been developed. We believe that the peculiarities just mentioned tend to confirm (if confirmation be necessary) the views we have expressed as to the origin of the larger fibrous growth. We confess we see no grounds whatever for regarding it (with the gentleman who brought it before the Society) as an ovarian tumour; we are unacquainted with any ovarian fibrous growths which have attained any thing like the dimensions of this body; there is no evidence whatever to shew that ovarian tumours contain muscular

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fibre; and we cannot understand how, if the tumour under consideration were ovarian, the opposite ovary and its Fallopian tube should spring from it. Further, we cannot admit that the fact of the second ovary not having been found has any weight, for among so many adhesions and so great a displacement of parts, it is not surprising that it should have been cut off, and so escaped detection—a suspicion, confirmed by the total absence, with the *ovary* of its corresponding *Fallopian tube*.

The absence of the cavity of the uterus, and the extreme atrophy of the organ, demand a little attention, inasmuch as the uterus generally becomes enlarged rather than atrophied, when fibrous tumours are present. In this case two tumours only existed, but they were large, and had become pedunculated, and it is evident that between them the uterus had been pulled out and attenuated. It is probable too, that in this case, as in others, the tumours were at first surrounded by the substance of the uterus, and that as they became detached they carried with them, as a capsule, a considerable portion of the uterine tissue, which has since wholly disappeared; and between these two processes, co-operating in the same direction, there can be no difficulty in understanding how the body of the womb should have been reduced to the remarkable condition in which it was found.

Dr. Bristowe.

Mr. Jonathan Hutchinson, *17th of February*, 1857.

The specimen was, at the desire of the exhibitor, further reported upon as follows, by Dr. West and Dr. Brinton:—

Second Report on Mr. Nunn's Fibrous Tumour.

We can come to no other opinion respecting this tumour than that it is a fibroid tumour of the uterus, partially ossified.

Not only does its structure seem incompatible with any other view; but its relations are equally conclusive. It is attached by a peduncle to the uterus, side by side with the stalk of a fibroid tumour, which only differs from it in its not being ossified. It has evidently elongated and narrowed the neck of the uterus, and has brought about the complete disappearance of the body of

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this organ. Finally, it has a situation and attachments characteristic of uterine, rather than of ovarian, tumours. Against this view, there is but one fact worthy of much notice; namely, the absence of the ovary of one side. But while admitting that this fact can scarcely be satisfactorily explained, we regard it as of little importance, taken in conjunction with the structural and relative anatomy of the tumour.

The congenital absence of one ovary is too rare an occurrence to form any safe explanation. It is not impossible, however, that in the dense mass of adventitious tissue which constitutes the periphery of this tumour, some relics of the missing ovary are present. [Indeed, there are traces of a tube, which crosses the degenerate uterine extremity of the Fallopian tube involved in this mass, and ends in an oblong closed cavity, with a dense fibrous wall, an irregular tuberculated inner surface, and serous contents. These structures seem not unlike the relics of the missing Fallopian tube and ovary.] In any case, rare as it undoubtedly is, for a fibroid tumour of the uterus to involve, and so far destroy, an ovary, we cannot see any inherent impossibility in such a supposition. To distort, occlude, and even divide, the uterus; to stretch and narrow the vagina; to lay open the vessels of the bladder or neighbouring viscera,—are events in the history of very large tumours of this kind, which may well suggest the possibility of equal injury to the ovaries.

Dr. West and Dr. Brinton,* *3rd of March*, 1856.

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11. *Extensive Disease of the Kidneys. Death preceded by Puerperal Convulsions.*

The degree to which the kidneys were affected in this instance, coupled with the absence of any marked amount of indisposition up to within a few hours before death, and the suddenness with which the latter event occurred, rendered this case one of unusual interest.

History.—The patient, æt. 26, was the wife of a shoemaker, living in a very destitute condition. She was the mother of

* For the portion included within brackets [ ] Dr. Brinton is alone responsible.

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four children. The history of her illness, very scanty in character, was as follows:—She had, it was said, been liable to gravel in the urine, and six weeks before her death, there had been anasarca of the lower extremities. Nothing very particular was noticed, however, until after the evening of the 30th of January, 1857. At ten o'clock on that evening, she was delivered by a midwife of a healthy child. The labour was natural, taking place at the full term of gestation. Three hours after delivery, urine was passed. Twelve hours after delivery, she was sitting up in bed, when she complained to the nurse that her sight was dim. She immediately after fell back in the bed, and the whole body became strongly convulsed. There had been a difficulty experienced in restoring warmth after the birth of the child, and from time to time there had been a complaint of pain in the chest, this having become aggravated just before the convulsive seizure. No other symptoms, however, were described. The fit lasted a short time, leaving the patient unconscious. After the lapse of about half an hour, another convulsive seizure, similar to the first occurred, and at two P.M., when I first saw her, five attacks had been noticed. The left side was the more violently agitated of the two, and the face became very dark during the fits, but no cry was uttered; the tongue had been bitten.

At two P.M., she was apparently unconscious, but turned on hearing the child cry violently; no answers to be elicited. The skin of a dingy, pasty appearance; eyes closed, pupils small, but slightly active; pulse weak, ninety. Respiration, sighing in character; occasional slight stertor. Mutters a little unintelligibly. Uterus well contracted.

Between two P.M., and six P.M., eight more convulsive attacks were noticed, at intervals of about twenty minutes.

At thirty minutes past seven, much altered for the worse. Coma has increased in intensity; mouth open; lips dry and brown. Since two o'clock twelve fits have occurred. One took place while under observation. The body first moved a little, the eyes opened, staring upwards, the hands and arms were stretched out, the respiration stopped, the arms became very rigid, the neck was bent backwards, the face became very dark,

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the arms were then violently agitated, the eyes rolling round, and squinting dreadfully. This condition lasted a few seconds, when the eyes became quieter, the arms oscillated less strongly, and after the lapse of about a minute and a quarter, respiration was resumed, and the arms fell on the bed. For a short time afterwards the respiration was slow and marked by stertor. After this hour two or three more fits took place and the patient died at 2 A.M., the 1st of February, twenty-eight hours after delivery, and sixteen after the first convulsion.

Post-mortem examination.—The pleura, pericardium and peritoneum, each contained a trifling quantity of serosity. The lungs and liver were much congested. Uterus presented nothing remarkable. The heart was hypertrophied and the valves a little thickened.

Kidneys.—The right kidney measured, vertically, ·15 met; transversely, ·075; thickness, ·045; weight, eight ounces. Capsule adherent; pelvis dilated; external surface of kidney nodulated, covered by a good deal of adherent cellular tissue, and mottled; the chief colour being a dull, yellowish-white, with no points intermixed. Section shews the cortical substance of a dull, yellow, semi-transparent texture, with dark-red striæ perpendicular to surface. Tubular substance atrophied. The further examination of this kidney shewed the organ to be in an advanced stage of granular fatty degeneration.

The left kidney measured, vertically, ·053 met.; transversely, ·02; thickness, ·01. Its weight was only 170 grains; the surface was irregular; the pelvis had the same size as that on the right side.

The bladder contained turbid reddish urine, which was found to hold in solution a very large quantity of albumen, and numerous tubular casts were seen under the microscope.

Dr. GRAILY HEWITT, *3rd of February*, 1857.

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12. *Hair-pin removed from the Female Bladder.*

The following case occurred very lately in the practice of my friend, Mr. G. Faithorn, of Chesham, Bucks. A young married woman, æt. 18, passed a hair-pin into the bladder, which she was using, according to her own account, to free the

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vagina from some secretion. This occurred some days before Mr. Faithorn was called to see her. He found her labouring under symptoms of irritation of the bladder, which, from her previous good health, and the foregoing history, left no doubt of the presence of a foreign body. On introducing a sound, a sensation was communicated to it of some substance lying in the posterior part of the fundus of that organ, which, however, did not give any metallic sound, no doubt in consequence of its being covered by deposit from the urine. The finger introduced into the vagina detected a body lying between the sound and the wall of the bladder, which appeared to correspond in shape to the pin which was said to have been introduced.

Mr. Faithorn determined to attempt the removal of the foreign body, at first by simply passing a pair of straight forceps through the undilated urethra; and if that should fail, to dilate this tube, and by passing in his finger, to endeavour to turn the pin, so that its bent extremity should come within the grasp of the forceps. Should this also fail, it might become necessary to resort to lithotomy. The first proceeding, however, was happily successful. He says, "Having injected the bladder, I had comparatively little difficulty in seizing the pin with either the straight or curved forceps; but the pricking character of pain on attempting to withdraw them, assured me that the point of the pin was towards me, and, after endeavouring to change its position unsuccessfully, I was obliged to relinquish my hold. This occurred several times, and I was on the point of dilating the urethra, and endeavouring to introduce my little finger; but on making one more attempt with the straight forceps, I seized the pin, and only communicated a dragging sensation on drawing the forceps towards me; my index finger in the vagina commanded the arm of the pin not held by the forceps, but I could not feel that I held it at the bent part. Determining on steadily withdrawing the instrument so long as I did not produce pricking or extreme pain, I put the woman in possession of my wishes, or, rather, reiterated them, and while I was carrying my intentions into effect, the woman made a sudden movement, and I have no doubt bent the pin against the os pubis, for its further

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removal was unattended with difficulty. She had some smarting on that and the following day, and passed a good deal of calculous matter, but has had no incontinence." Mr. Faithorn goes on to say, "Had I a similar case to treat again, I would dilate the urethra moderately, and introduce the forceps through a canula, as I could then use more force than I should be otherwise justified in doing." This suggestion is, no doubt, well worthy of consideration. Mr. Holmes, *3rd of February* 1857.

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13. *Ulceration of one Kidney, Sloughing of the Bladder, and Fistulous Opening between the Bladder and the Rectum.*

The subject of this disease, a middle-aged man, was admitted under my care into the Westminster Hospital, with extensive extravasation of urine, which had existed for four days previously. The distention was freely relieved by incisions, and the scrotum was sound; but the integument of the perinæum appeared to have almost lost its vitality, and a large portion subsequently sloughed; after which, the urine escaped freely from an orifice at the bottom of the wound.

A small catheter was introduced and retained, through which the urine flowed, and was occasionally ejected per saltum; nevertheless, the catheter could not be satisfactorily passed into the bladder; the point probably hitched in the vesical orifice of the fistulous canal, which appeared to be of long standing. The patient stated that no instrument had been passed for four years, and for some years previously, one of very small size only.

The fistulous communication with the rectum was inferred from the passage of some apparently vesical mucus, per anum. The patient sank from exhaustion. The slough contiguous to the neck of the bladder, probably comprises the strictured portion of the urethra. There was also a very much constricted congenital phimosis.

Mr. C. Brooke, *17th of February*, 1857.

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14. *Specimen of Atrophied Kidney.*

This was taken from a boy, æt. 15, who died of peritonitis. With

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the exception of a mild attack of measles at an early age, he had always enjoyed good health. On making the *post-mortem* examination, the right kidney was found from two to three times its natural size, but healthy, and occupying its normal position; but, on the left side, a mass was found, *weighing about a drachm*, and occupied by cysts. A few of these cysts were filled with fluid, but most of them were collapsed, and had corrugated walls. The microscope shewed the entire body to be made up of fibrous tissue, white and elastic, among which were found microscopic cysts, atrophied Malpighian bodies, and altered renal tubes, in such abundance, as to leave no doubt of the nature of the specimen. In the site of the pelvis of the kidney was an emulgent vein, pervious; but the artery and ureter formed impervious cords.

Dr. Sydney Jones, *3rd of March*, 1857.

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15. *Medullary Cancer of the Testis from an Infant.*

The specimen, which was quite recent, having been removed by operation that morning, was a good example of the brain-like cancer. It was nearly the size of a fist, without cysts, and without extravasation of blood. Large portions in the interior had undergone fatty degeneration, and were in the condition known as "saponified cancer." The patient was a little boy of nearly two years old, in fair health and well grown. The increased size of the testis had been first noticed about ten months ago, and the gradual growth had been almost painless. The cord not being diseased, and there being no signs of affection of the lumbar glands, Mr. Hutchinson had deemed it a suitable case for operation. The scrotum was somewhat adherent to the gland, and was crossed by numerous large veins. While the patient was under chloroform, just prior to the operation, it was deemed best to further confirm the diagnosis by introducing a grooved needle, and examining under the microscope the obtained matters. This showed cancer nuclei, and cancer cells in a state of fatty degeneration, the needle having entered one of the saponified parts. The operation was accomplished without much bleeding, the whole of the cord being tied *en masse*. Two of the boy's paternal aunts had died of scirrhus of the breast. Mr. Hutchinson ad-

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verted to the rarity of cancer of the testis in children. The only examples of which had fallen under his own notice were one under the care of Mr. Luke, in which the boy was æt. only 4, and a second under that of Mr. Canton, in which he was æt. 9. Mr. Earle had, however, recorded ("Medico-Chirurgical Transactions") a case in which the boy was but a year old at the time the disease commenced.

The child afterwards recovered well, and six months after the operation he was in good health, and without any indications of return of the disease.

Mr. HUTCHINSON, *3rd of March*, 1857.

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16. *Portion of an Ovum expelled at the full period of Pregnancy.*

This portion of ovum, which resembles a small placenta, from which the cord and thinner portions of membrane have disappeared, was expelled from the uterus on the 4th of March last, after a modified labour of six hours' duration, attended with a good deal of hæmorrhage. The evidence of it having been retained until the full period, is as follows:—In October last the patient engaged me to attend her in her expected confinement in March, she being then four months' advanced in pregnancy, the catamenia having ceased since the middle of June. The usual signs of pregnancy existed until the 18th of October, when she had a discharge of blood, which continued until Christmas, but was only very slight after the first two days. She had also during this time constant pain in the back, and no longer increased in size; but she was not conscious of a solid substance having passed from her at any time. The pain and slight hæmorrhage entirely ceased at Christmas. Since then she had a continued discharge of watery fluid and whites, but no return of pain until the specimen exhibited was expelled.

Mr. THOMAS BALLARD, *17th of March*, 1857.

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17. *Cancer of the Prostate.*

J. B., æt. 65, with history of tubercle in the family but not of cancer, and living in the country, was well up to twenty-two months

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before his death, when he began to have pain in the sacral region, which gradually increased, but did not lay him up till fourteen months before death. He then had hæmatemesis for a few days. This returned profusely in four months, for a short time. The symptoms, while he was under my observation, up to his death (five months) were almost the same with the exception of gradually increasing debility. A sallow complexion; intensely phosphatic urine; difficulty in emptying the bladder; but no stricture, nor difficulty in introducing a No. 8 catheter.

A large hard nodulated swelling in the region of the prostate rectum.

Enlarged inguinal glands. Neither these nor the prostatic swelling increased perceptibly in size during five months, but the prostatic tumour became softer, corresponding to a circumscribed softening found after death.

Pain was most intense in the sacral region, and could not be subdued by anything but very large doses of opium. None referred to bladder, or perinæum.

Post-mortem, on the 25th of March.—Prostate about five or six times its normal size—about the normal consistence. The scrapings, under the microscope, shew abundance of the ordinary form of cancer cells. Vesiculæ seminales similarly affected; and the disease had also invaded those parts of the bladder nearest to the prostate. No softening anywhere, except in the posterior part of the prostate, where there was a cavity filled with a grumous semi-fluid material, separated from the cavity of the rectum only by the coats of the gut, which, however, seemed healthy.

The inguinal glands on both sides were hard, about walnut size, and cancerous; shewing cancer cells under the microscope.

No other organs were affected.

Some large phlebolites of the size of small peas were found in the prostatic veins.

Dr. Armitage, *17th of March*, 1857.

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18. *Congenital Extroversion of the Bladder.*

The child, which was exhibited alive, was a healthy male infant, six weeks old, born at the full period, on the 25th of

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February, the mother being forty-two years of age. This was her third child, and nothing unusual occurred at birth. On examining the sex of the child, it was found to possess the deformity known as extroversion of the bladder. The anterior wall of the bladder was absent, associated with a deficiency in the corresponding part of the abdominal parietes. The posterior wall of the bladder was pushed forwards by the pressure of the bowels, and a tumour was consequently formed, which projected above the pubis, the size of a peach. It was prominent, round, and globular, the mucous membrane being of a blood-red, shiny colour, with the papillæ distinctly prominent, the orifices of the ureters projecting forwards, at the lower aspect of the tumour, the size of peas, from which flowed urine drop by drop. The penis projected forwards, apparently from the sides of the pubes, was irregularly developed and rudimentary, the glans which was divided into two portions, constituting its greater part; the urethra was an open canal, running along its very short dorsum, with a fold of foreskin situated beneath the glans. There did not seem to be any corpus spongiosum, although the corpora cavernosa were present, so far as could be determined. The ossa pubis were widely separated, and a peculiar prominent appearance was given to each groin, as if femoral herniæ were present, although none existed. The testes were in the scrotum. At birth there was some cutaneous inflammation between the navel and upper margins of the tumour, which afterwards disappeared; and, in the course of some days, the prominence of the tumour became sensibly diminished, somewhat contracted and flattened, and assumed a deep pink colour, instead of the blood-red. Drops of urine still flowed as usual, but occasionally in streams, when the child cried. The general health continued good, and it suckled well. The orifices of the seminal ducts, although undoubtedly present, could not be distinguished. The ureters will become dilated into pouches after the lapse of a certain period, and will thus form reservoirs for the urine, with the possibility of acquiring the power of expulsion.

The malformation would seem, in the present instance, to be associated with an imperfect development of the rectus and pyramidalis muscles of both sides, a peculiarity which almost always

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is found to be co-existent. Moreover, there is the presence of an umbilicus. This was absent in Mr. Earle's cases, and others referred to in Mr. Coulson's recent work on "Diseases of the Bladder." In five other instances, seen by myself, all in males, four in children, and one adult, the drawing of whom was exhibited, the navel was absent. In the last there was also no urethra whatever. Dr. GIBB, *7th of April*, 1857.

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19. *Disease of the Kidneys.*

G. G., æt. 36, a carpenter, was admitted into St. Thomas's Hospital under the care of Dr. Risdon Bennett, the 7th of April, 1857. He stated that he had not been well since an attack of variola two years previously; that for about four months he had had pain of the loins, with frequent calls to pass water, and that since February he had not had perfect control of the bladder. On admission he was a good deal emaciated, had a flushed face, and an air of suffering, the skin was dry, the pulse quick, and the breathing hurried. The urine, which was passed frequently, and in a measure involuntarily, was pale, abundant, of low specific gravity and deposited a certain amount, not great, of muco-purulent matter. It gave no indications of either sugar or albumen, but the general aspect and condition of the man was very much that of a person in the last stage of diabetes, and his intellect appeared to be somewhat enfeebled. There was tenderness over the region of the bladder, and no other marked local symptom. On the 14th, he was becoming typhoid, and began to sink, and on the morning of the 15th, had low muttering delirium, but answered questions distinctly on being roused. In the evening of the same day he died.

Post-mortem examination.—Weight, seven stone eight pounds; height, five feet nine inches; moderate emaciation. In the left pleura there were no old adhesions, but the surface of the lung was covered with patches of recent granular lymph, some almost purulent in appearance. Hard, grey, tubercles were distributed through the left lung, most numerous and largest in the apex, which was puckered, and contained some cretaceous masses. The right pleura was healthy, but the right lung, like the left,

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was studded with hard tubercles, and the apex puckered and exhibiting the remains of old tubercle. The heart, pericardium, and peritoneum, were all healthy. The liver was large, soft, and rather pallid; the spleen firm, but light-coloured.

The left kidney was much enlarged, and its surface lobulated, by the presence of a series of cysts, the projecting portions of which varied from the size of half a hen's egg downward. They had a doughy feel, and an opaque, whitish aspect. On section, the entire organ appeared to be converted into a series of cavities, some of which might have held a small orange, and all filled by a thick, opaque, white material, resembling, both in colour and consistence, clotted cream, but having more of the density of putty. The contents of one or two of the cavities were more fluid. The cyst walls, *i.e.*, both those portions of the remains of the kidney-structure which bounded the cysts, externally, and those which formed the septa between adjoining cysts as well as those which divided them from the infundibula and pelvis of the organ, were not above half a line in thickness. The pelvis of the kidneys was filled with a material like that in the cysts, and its walls were very much thickened.

The right kidney weighed one pound two ounces. On removing its capsule the surface was found to be thickly studded with whitish projecting nodules from one to two lines in diameter. Most of these were collected into groups, and some adhered to the capsule. On section, the substance of the organ, including both the medullary and cortical portions were found to present numerous masses of opaque, buff-coloured, tolerably firm material, exactly resembling tubercle. The masses varied in size from that of a horse-bean downwards. Some were rounded in shape, some elongated vertically to the surface. They were distinctly circumscribed and surrounded by congested tissues. A few had begun to soften in the interior. In the upper half of the organ were three or four cavities of somewhat irregular shape, and about an inch in diameter, which were filled with flaky, puriform fluid, and the parietes of which were formed of breaking-down tubercle. Some of these communicated by ulcerated openings with adjoining calyces. The mucous membrane of the pelvis and infundibula was much thickened and

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congested. Two ureters were connected with the left kidney, which united about three inches from the hilum. They were filled with inspissated matter resembling that in the left kidney, and their walls were considerably thickened. The first inch or two of the common ureter was affected in the same way. The supra-renal capsules and the pancreas were healthy, as were also the stomach and small intestines. The only abnormal appearance within the head was a higher degree of congestion than usual in the white substance of the brain.

Dr. Risdon Bennett, 21*st of April*, 1857.

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20. *Malignant Disease of the Kidney, &c.*

A. K., a female, æt. 5½, had fair health till six months before death, when, for some slight indisposition, medical attendance was obtained; but, though the patient did not regain her usual health, yet she so far recovered as not to require further treatment till about two months before death, when attention was first drawn to a swelling on the right side of the abdomen, mainly in the hypochondriac region, but extending into the lumbar and iliac regions on the same side. The dulness, on percussion, over the whole tumour was continuous with that of the liver, which was looked upon as the seat of the disease. The most marked symptoms were loss of appetite and progressive emaciation. The tumour increased rapidly in size, and became very elastic and distinctly fluctuating; so much so that an exploratory puncture was made, which gave vent to fluid of serous character. No urgent chest symptoms presented themselves till just before death.

The right kidney, upon being removed from the body, was found to measure eight inches in length, and five and a half inches transversely; it weighed four pounds and a half, and was almost entirely transformed into a mass of soft, white, encephaloid cancer, exhibiting a cystic appearance. Upon section, about a pint of clear, serous-looking fluid escaped; several of the calyces could still be seen, and at the lower end was a small portion, about a line in depth, immediately beneath the capsule, which, to the naked eye, appeared to resemble, and upon microscopical exami-

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nation proved to be, kidney structure. The fluid which escaped upon section contained numerous small fragments of the cancerous mass.

The left kidney was healthy, and not larger than natural. The left lung was entirely converted into a mass of cancer of the same kind, and when removed from the body, could not be recognised, nor could any trace of lung-structure be observed.

The right lung was found to contain one nodule of cancer, about the size of a small walnut. No cancer was found in any other organ.

The microscopical appearances were, on the whole, those of cancer, though no single cell could be found specially indicative of malignant disease.

Mr. Balding, 19*th of May*, 1857.

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21. *Recurrent Fibroid Tumour of the Uterus assuming a Polypoid Shape; three times partially removed.*

Miss J., æt. 39, the daughter of a small farmer in Lincolnshire, was first seen by me in April, 1855. She was then stout, and in fair health, but pale from repeated floodings which had occurred during the preceding nine months. This, with a sense of weight and dragging in the womb was the only symptom which she mentioned, and she assured me that she had always before enjoyed excellent health. I made a vaginal and rectal examination, and noted in writing that the "posterior part of the body of the uterus appeared enlarged, and as if containing a fibrous tumour." The os and cervix were in every respect normal. A course of the sal ammoniac was ordered, and rest in the recumbent posture. She returned into Lincolnshire, and I heard no more of her until June, 1856, when she was again sent to town to be under my care, by my friend Dr. Cammock, of Spalding. She was now confined to bed and extremely feeble. Her aspect was blanched and pale to a degree, and she had lost much flesh. Her mother stated that she had been under the care of several medical men, but that the disease had been steadily advancing. The floodings had been the main symptom and had been so profuse that on one or two occasions she had been

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supposed to be dead. On examination, I found the uterus greatly enlarged and projecting in the median and left iliac regions, so as to be distinctly visible. It felt about the size of a child's head, and was only partially moveable, its projection to the left side being marked. The vagina was occupied by a lobulated polypoid mass, the size of three fists, with a pedicle the thickness of a wrist, which connected it with the intra-uterine growth. As as far as the finger could reach up the cervix uteri, the growth had no attachment to it, and the mucous membrane of the vagina, os, and cervix, was perfectly healthy. The tumour hung as low as the ostium vaginæ, it was smooth throughout, softish to the touch and deeply lobulated. The discharge was offensive, and on some spots there were superficial sloughs. The aspect of the case was so unpromising;—the growth had been so rapid, and the patient's aspect so much resembled that of malignant disease,—that we were at first unwilling to entertain the idea of any operation. On further consideration, however, it seemed clear that the patient could not long survive if let alone, and that matters could not easily be made worse, and we determined to attempt the removal of the growth. In this decision, I was supported by my friend, Mr. J. H. Jackson, who attended the case with me.

On the 28th of July the first operation was performed. It consisted in the introduction of the hand into the vagina, and the attempt to pass it into the uterus, which, however, could not be accomplished. The texture of the tumour was so soft, that in this attempt to enucleate, it tore readily, and some rather large portions came away without much bleeding. Having found, after a patient trial, that the hand could without undue violence be made to enter the uterus itself, I tried by means of large lithotomy forceps, and a blunt hook, to drag the growth down so low as to allow of a ligature being put upon its base. In this endeavour, also, some portions were detached and brought away. It being impracticable to put a ligature higher than what appeared to be the middle of the growth, it was not applied. The procedures had altogether lasted about half-an-hour; the bleeding had not been profuse, but when I desisted, I was under the impression that nothing had been done which would be of any

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advantage to the patient, and the case was beyond operative aid. The portions which had been got away did not amount altogether to more than a sixth of the probable bulk of the tumour; but the latter had been much lacerated and contused. The vagina was plugged with sponge to prevent further bleeding. Plate V. Fig. 1, represents one of the portions removed at this operation, and gives a good specimen of the whole. The appearance of the constriction shewn, is evidence only of the division into lobes which existed: no ligature had been applied to it. Its texture was throughout homogeneous and it was of a dead, grey-white colour. It contained no juice, and very readily tore up into fibrils, all of which had a parallel arrangement, resembling decolourised solid fibrin from an aneurism, Fig. 2. Under the microscope, nuclei and numerous small cells were seen, which are accurately represented in the engraving from a camera sketch by Mr. Tuffen West, Plate V. Fig. 3. There appeared, therefore, no histological evidence on which to regard this tumour as a cancer, whilst, on the other hand, it was perfectly distinct and very different from the ordinary uterine fibrous tumour.

With regard to the patient's progress after the operation, it may be stated, that for about two weeks, she remained in a state of most critical debility. During this time there was copious fetid sanious discharge, and masses of slough came away. It is remarkable, however, when we note the conclusion, that no masses of large size were observed. At the end of a fortnight, her mouth, which had been aphthous, cleaned, she regained her appetite, and began her convalescence. In a month later she was able to get about the house, and was wholly free from symptoms. Mr. Jackson and myself made most careful examinations and satisfied ourselves, that not only was the vagina quite free, but the uterus was again reduced to near its normal size. The cervix had now its natural length, and the os was contracted. By the abdomen no tumour whatever could be felt, although the patient permitted of the deepest pressure, and the abdominal walls were very flaccid.

For about three months after this time, she enjoyed good health, much better than she had ever had since the commencement of her malady; had no hæmorrhages whatever, and often

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walked distances of several miles. There remained, however, an occasional œdema of the ankles after long standing, which shewed the poor condition of her blood. The urine was not albuminous. She gained strength, and acquired colour with such rapidity, that on one occasion, after having not seen her for a month, I did not recognise her.

Our faint hopes that the recovery might prove a permanent one were, however, dissipated in the early part of December by another flooding, and by the discovery that the uterus was again enlarged to a considerable size. Throughout the rest of the month she was confined to her bed by frequent and profuse hæmorrhages, and again lapsed into a most exsanguined condition. At her own request, in the latter part of the month, I made a second attempt at enucleation, my friends Mr. Corner and Mr. Moon being present and assisting. The patient was put under the full influence of chloroform, and placed on her back at the edge of the bed. It should be stated that the uterus was now about as large as three fists, and rounded, and freely mobile. The os uteri was well dilated, and some lobules of the growth, apparently in process of expulsion, existed in the vagina. Carefully steadying the uterus with my left hand, I introduced my right into the vagina, and thence into the cavity of the uterus itself, a procedure not accomplished without much difficulty, the vagina, &c., being very narrow and rigid. Making the fingers assume the form of a scoop, I passed them over the interior of the fundus, completely lacerating and breaking up the tumour, which was again too soft to permit of removal *en masse*. It appeared to grow from the whole interior of the fundus and posterior part, having no attachment to the anterior part or lining of the cervix. Numerous portions were brought away, and a good opportunity was again afforded for examining the texture of the growth, which in every respect precisely corresponded with that formerly removed.

The patient's progress afterwards was very much what it had been before. The exhaustion was again extreme, and continued for some time, during which many portions of sloughy tissue were expelled. It should be stated that the ergot had been fully tried before the operation, and was again resorted to afterwards.

On examining the parts a week after the operation, I was much

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astonished and annoyed to find a communication of very considerable size between the vagina and rectum, extending in fact from just above the internal sphincter to within an inch of the posterior lip of the uterus. This had probably resulted from ulceration, in consequence of over stretching during the manipulation. That it did not result from a tear during that procedure was certain, since it could not have escaped detection in the several examinations made with the finger after withdrawal of the hand. Beyond the careful syringing out of both vagina and rectum, no treatment was adopted for this, and strange to say, it caused very little inconvenience, the fæces, excepting during diarrhœa, never escaping by the vagina.

The patient again recovered well, and again the uterus seemed reduced to dimensions but little, if at all, larger than natural. She was for months sufficiently well to go about ordinary duties, and even went into the country, to officiate as bridesmaid at a sister's wedding. In March, however, the old symptoms again returned, and a large growth was found in the uterus. She was now confined to bed, and much reduced. Being loath to do any further operation, we made a partial trial of the chloride of zinc, in dilute solution, which, by means of a small catheter pushed into the substance of the tumour, I injected every third day in quantities of from one ounce to one ounce and a half. In this way some sloughs were got away, but the plan caused much annoyance and pain, and as the tumour still grew, it was desisted from in the early part of April. The tumour now grew very fast indeed, and was even partially extruded at the vulva. The patient being almost moribund, and suffering exceeding pain from the distention of the vagina, I applied a ligature, by means of Gooch's canula, to the growth at the level of the os uteri where it was constricted. It cut through in two days, and the vaginal mass having been removed piece-meal, she passed the last fortnight of her life in comparative comfort. Death from exhaustion, consequent on hæmorrhage, sloughing, and discharge, took place in the first week of May.

At the *post-mortem examination* every organ in the body was found in a state of health, excepting the uterus and vagina. The corpse was moderately fat, but completely exsanguined. The uterus was pear shaped, anda bout the size of two fists. It exhibited

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old adhesions to the colon and other adjacent parts. Its surface was quite smooth, but of very unequal firmness. On section, it was found to contain a white soft growth, which attached itself by a very broad base, to the whole of its fundus and posterior surface, and the free extremity of which hung about level with the os, Plate V. Fig. 4. The mucous lining of the cervix, excepting in being congested and discoloured, was healthy. The uterine walls were much thickened in those parts to which the tumour had no attachments, but were thinned evidently by its infiltration at its base of growth. The tumour itself was much more succulent, but in other respects resembled the portions formerly removed. The rent in the recto-vaginal wall had contracted to a length of about an inch, and was quite vertical. The colon contained much hardened fæculent matter.

In designating the tumour described in the above case, as a recurrent fibroid, I am guided not only by its histological elements, as ascertained on three several occasions, and by several independent observers, but by the general progress of the case.

The tumour grew far too rapidly for a fibrous tumour, and was also too soft and too much lobulated. Fibrous tumours besides do not reproduce themselves after removal, and although in this case on neither occasion was the removal complete at the time, yet it became practically so afterwards. That there were no other deposits in any organ of the body, although the disease had existed three years, and had been repeatedly interfered with, is, I think, strong testimony against its having been a true cancer. On the other hand, its mode of development, its rapid growth, and its assumption of the polypoid form, remarkably resembled what I have repeatedly witnessed in the recurrent fibroids in other parts of the body. These are remarkably liable to fungate, and to assume a pedunculated form. It should have been stated that a paternal aunt of the patient had had a tumour removed from the breast, which she had been told by the surgeon was cancer; she is, however, after the lapse of ten years still living. The recurrent fibroids undoubtedly occupy a position of close relationship to the true cancers, and the fact of their occurring in the blood relations of cancerous patients is a point in their

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DESCRIPTION OF PLATE V.

The figures illustrate Mr. Hutchinson's case of Uterine Tumour, p. 287.

Fig. 1. Portion of the tumour removed in July 1856; the constriction is natural; no ligature had been employed.

Fig. 2. Portion teased out with needles, shewing its resemblance to the fibrine of blood.

Fig. 3. Microscopic structure of the same.

Fig. 4. Section through the uterus and abnormal growth, shewing the extensive origin of the attachment of the latter.

Figures 5 to 10 illustrate Dr. Bristowe's and Dr. Priestley's Report on the Microscopic Structure of the Tumour, p. 293.

Fig. 5. Fibroid tissue from the denser portion of the tumour.

Fig. 6. The same, acted on by acetic acid, shewing nuclei.

Fig. 7. Edge of section of the soft tissue of the tumour in a normal condition.

Fig. 8. Detached nuclei or cell-like bodies.

Fig. 9. Elongated cells occasionally met with.

Fig. 10. Edge of a section of the degenerate portion of the tumour.

Figs. 1 and 4 reduced one fourth in size.

Figs. 3, and 5 to 10 much magnified.

Fig. 2, of the natural size.

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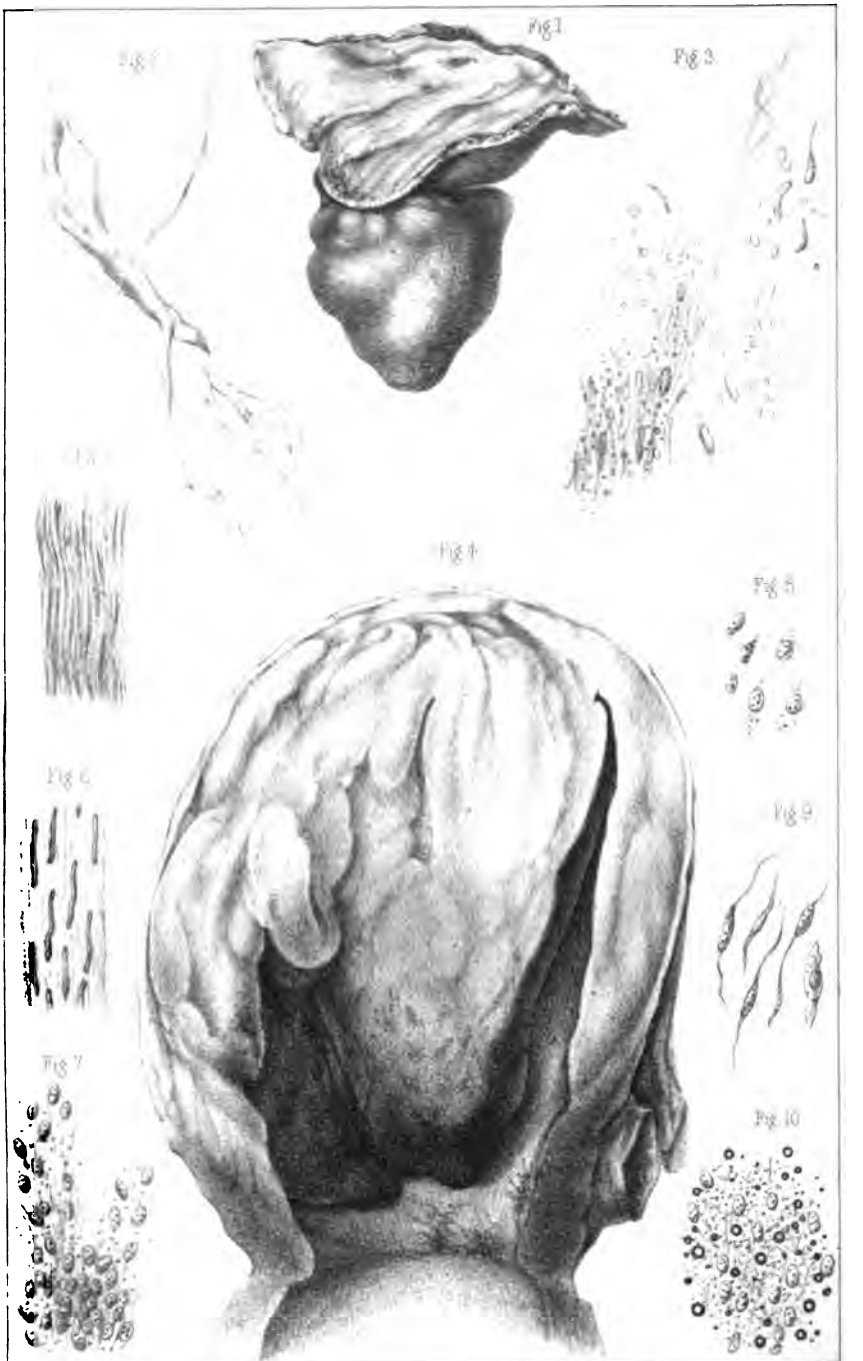

J. S. Templeton M.D. & J. W. del. Pall Mall West S.W.

W. West, Imp.

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history which has been well proved by Mr. Paget, and which my own observation has often confirmed.

Mr. Hutchinson, *October*, 1856, *and 5th of May*, 1857.

Report on the above case.—The tumour appeared to the naked eye to consist of two distinct elements—first, a tough, greyish, glistening, fibroid structure—second, an opaque, cream-coloured material, which was soft, elastic, close grained, perfectly homogeneous in appearance, and yielded no sort of juice either on pressure or by scraping.

The fibroid structure was most abundant in the basal portion of the tumour; it was directly continuous with the uterine walls; and, extending for various distances into the growth, formed a series of loculi, which were of different sizes, and which as a rule became larger and larger as they receded from the base, until at length they vanished, and the fibroid element became wholly lost in the substance of the tumour. The softer material filled the loculi formed by the fibroid tissue, and alone constituted the distal, and larger portion of the polypus.

The sectional surface of the base of the tumour had very much the same appearance as that of a cirrhosed liver; for the fibroid tissue had exactly the same arrangement that it has in cirrhosis, and the softer material that filled up the interstices, owing to its elasticity, projected in a hob-nailed manner above the general surface. The two forms of tissue moreover were firmly united with one another.

That part of the uterine walls, from which the tumour grew, was very much thinner than natural; but some portions, in the immediate neighbourhood, were thickened and contained nodules of the softer formation, which appeared to be more or less isolated.

The fibroid portion of the growth consisted, partly, of fibroid tissue taking a wavy course, Plate V. Fig. 5, and presenting elongated nuclei, which were rendered very apparent under the influence of acetic acid, Fig. 6; and partly of organic muscular tissue. It displayed, in fact, as nearly as possible, the same structures as the healthy parts of the uterine walls, and was

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clearly, therefore, a prolongation of the tissue of the uterus into the substance of the tumour. The soft material was constituted chiefly of nuclear bodies of a round or ovoid form, Fig. 7, which varied from $\frac{1}{2600}$th to $\frac{1}{4000}$th of an inch in diameter. They could not be washed, or indeed readily detached in any way, from the matrix, so that comparatively few could be seen floating about the field of the microscope. When free, they presented usually, adhering to them, shreds of a granulo-fibroid material, Fig. 8, but in no instance could we discover that any of them were surrounded by a distinct cell-wall. These bodies were united with one another by means of a very indistinct and delicate fibroid net-work, which was rendered more indistinct than it would otherwise have been, by the presence of exceedingly minute transparent molecules, which appeared to adhere to the fibres, Plate V. Fig. 8. In addition to the above, the soft portion of the tumour presented here and there fusiform cells (?) containing elongated nuclei, which belonged probably rather to the fibroid matrix than to the cellular growth, Fig. 9. In those parts of the tumour which were most distant from its origin, the tissue was studded with oil globules of different sizes, and the nuclear bodies were comparatively few in number and very indistinct, Fig. 10.

In one situation a small cavity was discovered filled with pus-like fluid; under the microscope this was found to contain numerous compound granular cells of different sizes, and round, delicate-walled, more or less granular bodies, which were supposed to indicate a degenerate condition of the normal cells of the growth.

As regards the nature of the above polypus, we find a greater difficulty in stating to what class of tumour it does belong, than in pointing out those classes of tumours to which it does not belong. It is certainly not a fibrous tumour of the uterus, for it has neither the naked eye nor the microscopic characters of that form of growth, and its mode of connection with the uterine walls, and its history, are alike adverse to that view. It does not bear any marked resemblance to glandular or to mucous polypi. Neither does it present the characters of any of the forms of cancer usually met with; it has not the least resemblance to

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either scirrhous or epithelial cancer, and only a certain amount of resemblauce to encephaloid cancer. The chief points in which it resembles the latter form of disease, are first, its extreme rapidity of growth; second, its progressive encroachment on the uterine walls; and third, the preponderance of the cellular or nuclear elements over the fibrous. The chief points in which it differs from encephaloid, are first, its consistence, for though lacerable, it was flabby rather than pulpy; second, the absence of cancer-juice, and the peculiar coherence among its elements on which that absence depended; and third, the absence of all secondary manifestations, notwithstanding the length of time the primary disease had been in existence.

Dr. Bristowe.

Dr. Priestly, 19*th of May*, 1857.

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22. *Polypus of the Rectum.*

E. G., æt. 5, came under my observation upon the 23rd of March, amongst the out-patients of Guy's Hospital, having experienced constant bleeding from the anus, for three weeks previously, unaccompanied by pains, and, although frequently examined by his mother without any visible cause.

On examining the patient, the buttocks were found smeared with blood, and, projecting from the anus, a small polypus, the size of a horse-bean, was detected; this having but just come down. It was excessively vascular and conjested, and had a neck about three-quarters of an inch long, connected with the bowel within the sphincter.

As the boy was an out-patient, I applied a ligature to the base, to prevent all chance of bleeding, and, having done so, the sphincter contracted and expelled the polypus. When seen, three days after, the boy was quite well. Upon examining the growth microscopically it presented the usual appearance of a fibro-cellular structure.

Mr. T. Bryant, *7th of April*, 1857.

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23. *Two Specimens of Hydrocele of the Tunica Vaginalis.*

These were from a body affected by double hydrocele. The left held about six ounces of fluid, and the right about one ounce and a half. In both an unusual appearance was present before they were removed from the scrotum. The testicles were felt quite distinctly, and quite at the inferior part of the tumour, instead of being obscured by it, and placed at the posterior wall as is usually the case. The appearances led to the inference at first, that they were specimens of encysted hydrocele of the tunica vaginalis. There was also present an unusual degree of the transverse constriction often seen in hydrocele and hernia, giving an appearance of two distinct oval tumours placed one above the other.

On opening the tumour, the testicle and epididymis were found lying entirely at the bottom of the sac. The gland was not placed obliquely in its usual fashion, but almost transversely, as if borne down by the weight of fluid, and the fibrous tissues immediately connected with it, and the epididymis were much more developed and stronger than usual; this was probably the cause why they had not yielded downwards so much as is generally the case in this disease. The constriction was found to depend upon a greater and stronger accumulation of fibrous tissue passing transversely across the sac near its centre, and proceeding from the investment of the cord posteriorly. The sac of the smaller tumour was at this point a quarter of an inch thick, and in some places nearly cartilaginous. It had extended more freely upward posteriorly along the cord than at the anterior part. It was rough and irregular in its interior, and at one part a band of adhesion extended across its cavity. It seemed as if it had been at one time injected.

Mr. J. Wood, 19*th of May*, 1857.

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VI.—DISEASES, ETC., OF THE OSSEOUS SYSTEM.

1. *Acute Osteitis and Periostitis of the Tibia.—Amputation.*

J. D., æt. 14, a tolerably healthy but delicate looking lad, was admitted into Marylebone Infirmary the 22nd of August. Three days before he had been kicked on the right shin by a lad at school; the skin was not broken. He felt little pain, and complained of it again next day. The following day it was swollen, and he was admitted to the Infirmary. The following notes were taken:—

August the 23rd.—The right leg has a pale, somewhat œdematous look; it is considerably swollen—fluctuation perceptible over the upper third—a free incision gave exit to deep-seated matter—condition rather weak. During the next few days fresh matter formed, and fresh incisions were made. In the commencement of September, denuded bone could be extensively felt through three openings. He is weak, but is supported by stimulants and good diet.

September the 11th.—The right knee-joint has become painful, and a little swollen. Inflammation has evidently extended to it.

After a day or two, tenderness in the line of the femoral vessels appeared, and an abscess opposite to the lower fifth of the femur, just above the joint, and to the inner side, which was opened.

September the 19th.—The discharge having become very profuse, and the patient's general condition precluding the hope of his possessing power to bear up during the process of reparation, I decided to-day to amputate the femur at its middle third, and did it in the usual manner, by anterior and posterior flaps.

Examination of the limb.—The upper half of the tibia is detached from the soft parts around, and bathed in pus, containing fragments of disintegrated tissues. The cavity of the knee-joint contains pus also, and communicates with a larger abscess, situated opposite the lower part of the femur, at the inner side.

Condition of the tibia.—The upper three-fifths of the bone is of a yellowish colour, denuded of periosteum, and obviously in a state of necrosis, excepting a thin layer of the outer portion of

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the head, which is in contact with the periosteum, and maintains its vitality. The larger part of the head is necrosed, and its upper surface, in the cavity of the joint, is denuded of articular cartilage; portions of the latter being attached to the borders of the articular surface, loosely overlying the dead bone. The periosteum of the shaft has disappeared entirely from the necrosed portion, but, below this, upon the sound part, it remains. On detaching its free edge, and dissecting it backwards from its sub-periosteal attachments, a line of demarcation between the sound and the dead bone is very manifest, a narrow and shallow groove existing, filled with pus. Besides this, the reflecting of the periosteum brings the following into view:—A pink layer of bony matter, about one-twentieth of an inch thick in some places, one-twelfth in others, freshly deposited, covers the whole of the healthy shaft to the distance of two or three inches from the dead portion. It is easily separated from the healthy shaft beneath, and may be peeled off like bark from a tree. Its presence is limited strictly by the existence of healthy periosteum and bone, between which two it has been deposited as a layer, and to each of which it adheres with about equal tenacity. Both the healthy bone and periosteum are rather more vascular than they are in other parts, where this formation does not exist, as evidenced by the pink hue, and the numerous red points seen in both. At one point, firm spicula project from the free edge of the layer, and overlap the dead bone. It is obvious that, although a period of thirty days only has elapsed between the receipt of the injury which gave rise to the necrosis, and the examination of the bone thus described, a very extensive amount of reparative action has been set up, and that a considerable attempt has been made by nature to strengthen the remaining healthy shaft, and to cover in the dead part as a future sequestrum. From the apparent vascularity, not only of the periosteum, but of the healthy bone, it might be inferred, that both structures have contributed, perhaps equally, to the formation of this new layer interposed between them. A portion of the newly-formed osseous tissue placed under the microscope, shews the deposit of earthy matter to be taking place in a fibrous matrix, precisely after the manner of the process of ossification,

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as it occurs in the flat bones, and which is described as intra-membranous ossification.

Mr. Henry Thompson, *21st of October*, 1856.

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2. *Necrosis after Frostbite.*

These specimens were portions of the distal phalanges of the great toes of men; one had been removed by bone nippers, the other had separated spontaneously. The dead portions of bone were black, and did not include the whole thickness of the phalanges. There was very little difference in the amount of bone lost in the two cases.

The specimens were brought forward in illustration of the results of two opposed systems of practice, to shew that much time may be saved by removing dead portions of bone by operation, if this can be done without injury to the soft parts. The cases had been very similar; but in the one where the bone was removed, the man was serving with his regiment many weeks before his comrade had left the hospital.

Mr. Spencer Wells, *4th of November*, 1856.

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3. *Fracture of the Os Calcis.*

This specimen shewed a portion of the superior surface of the os calcis, including the articular surfaces and the sulcus calcanei; it had been completely broken away from the rest of the bone.

The patient had fallen over a wall between twenty and thirty feet high. Great swelling came on followed by suppuration and separation of the specimen exhibited, but the patient eventually recovered a useful limb.

Mr. Wells stated, that although fracture of the os calcis by muscular action was well known and described in most surgical works, yet the fracture by crushing, here exhibited, had been almost overlooked by all British authors. It was first described by Malgaigne in 1843, and Mr. Wells felt sure that it was not of uncommon occurrence, and not recognised only because it was not known. The characteristic deformity was widening of the os calcis and sinking of the vault of the foot, the heel being

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lengthened behind, as might be found by measuring with a tape behind from one malleolus to the other, or from the heel to the great toe. Crepitation is obscure, but may be discovered by torsion or lateral movements of the os calcis. The patient complains of acute pain, is unable to walk, and there is great swelling which attracts attention to the inner malleolus. But the swelling is soft and compressible over the malleolus and on the dorsum of the foot, while beneath the malleolus there is a hard osseous projection formed by the os calcis.

Mr. Spencer Wells, *4th of November*, 1856.

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4. *Carcinoma of the Head of the Tibia, implicating the Knee-joint.*

The specimen was removed from a married woman, æt. 36, of a pale, sallow complexion, but in good bodily condition. About five months ago, she first noticed a prominence of the inner tuberosity of the right tibia. She complained of a good deal of darting pain, especially at night, and having had primary syphilis some short time previously, was treated for syphilitic periostitis. The swelling becoming more prominent, she was admitted into the Middlesex Hospital, under the care of Mr. de Morgan, remained there six weeks and was then discharged on refusing to submit to amputation.

On her discharge about one month ago there was a firm elastic tumour about the size of half an orange, just over the inner tuberosity of the right tibia. There was some fluid in the knee-joint and the tumour seemed to be advancing upwards. The disease being suspected to be malignant, amputation of the thigh was performed by Mr. Bradley, of Greenwich, under whose care the patient had been since her discharge from the Hospital. On examination, the tumour appeared to consist of two portions; the larger and softer portion about the size of a large egg, situated under the popliteus muscle, pushing forwards round the inner tuberosity, and being connected with the smaller and harder portion which pushed up into the knee-joint and outwards, as far as the inter-osseous ligament.

Mr. George Parkinson, *2nd of December*, 1856.

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DESCRIPTION OF PLATE VI.

Figures 1 to 3 illustrate the Microscopic Structure of Mr. Parkinson's Tumour of the Tibia, p. 300.

Fig. 1. Cells from the softer parts of the tumour.

+ Cells most frequent.

a. Remarkable compound cell with fat-globules at the circumference.

b. Caudate cell (a few of these were present).

c. Compound cell, bursting. Many fat-globules.

d. Free nuclei and fat-globules.

Fig. 2. Spindle-shaped cells, and granules from the portions of tumour involving the inter-osseous ligament.

Fig. 3. Cells and granules from the portions of Tumour invading the cartilage covering the tibial tuberosity—opaline, and containing bone spicula.

Figure 4 is a magnified representation of a Section of Bronze Skin, from a preparation made by Mr. Jonathan Hutchinson, p. 391.

a. Epidermis layer quite colourless and normal in texture.

b. Rete mucosum deeply coloured.

c. Elevations of the papillæ.

d. Cornu, or true skin, quite colourless and normal in texture.

Figure 5 represents Fibre-cells, from Mr. Hutchinson's case of Recurrent Fibroid Tumours of the Humerus, p. 346.

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Fig 1

Fig 2

Fig 3

John Wood del

Fig 4.

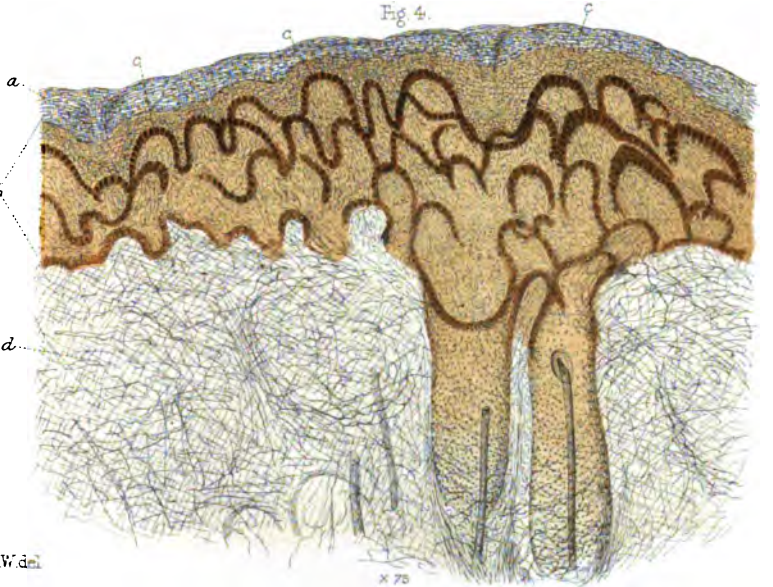

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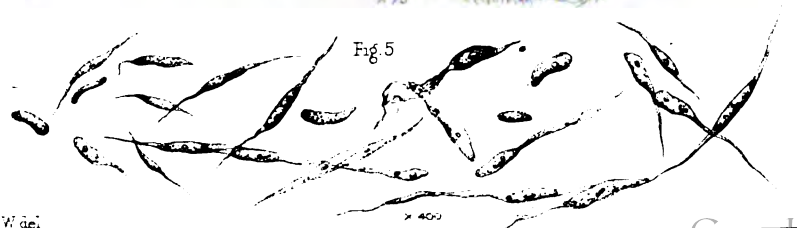
Fig 5



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Report on this specimen—The tumour, which was about the size of an orange, had apparently originated in the periosteum covering the tibia under the popliteus muscle and thence projected backwards into the popliteal space upwards and forwards into the knee-joint, involving the cartilage covering the internal tuberosity with a lesser projection forwards and outwards, between the tibia and fibula. The softest portion of the tumour was found in the site of the popliteus muscle, the outline of which was to be traced bound down by the popliteal fascia, though no muscular fibres were apparent under the microscope. There were found large, but various sized mother cells, round and oval, containing two, three, or more nucleated cells with much granular matter, Plate VI. Fig. 1. Many of them were studded with highly refracting globules of various sizes, and in some instances coalesced. These were apparently fatty matter. In the juice were multitudes of free granules and some fat globules. A few elongated fusiform compound cells were also found in this part of the growth. In that part involving the inter-osseous and other ligaments, the cells were likewise compound and granular, but uniformly elongated and fusiform, Plate VI. Fig 2.

In the part involving the cartilage were many cells of the same character as those in the softer parts, but the majority were oval, and some caudate. They had all an opalescent appearance, similar to that of healthy cartilage cells, having a greater refracting power than the cells in the other parts of the tumour but were still compound and granular, and varied much in size, as seen by reference to Plate VI. Fig. 3.

We think the microscopic appearances justify the inference that the growth is carcinomatous.

Mr. John Wood and
Mr. Parkinson, 16*th of December*, 1856.

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5. *Apparent Dislocation of the Vertebræ. Partial Reduction by extension and local pressure.*

F. A., æt. 34, a healthy labourer, fell from a scaffold, a distance of twelve feet, across a wall, upon his back. He was taken up powerless, and admitted into Guy's Hospital, one hour

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after the accident, on the 3rd of May, 1856, under the care of Mr. Cock.

On admission he was suffering intense pain over the lower dorsal vertebræ, the seat of injury; this pain shooting across the abdomen, and round the hips. Perfect paraplegia and anæsthesia of the lower extremities were present, with retention of urine and slight priapism. The skin was cold, the pulse fifty-two, and small. The only position he could lie in, on account of the pain, was upon his left side.

Eight hours after admission, chloroform was given, and a careful examination made, when a considerable depression and prominence over the lower dorsal vertebræ was most marked. Moderate extension and pressure over the projecting bones were applied with success; the deformity being considerably reduced, and the intense pain, which was previously experienced, much relieved, enabling he patient to recline upon his back.

Upon the third day, a peculiar catching cough, with slight bronchitis, made its appearance, but this soon disappeared.

Perfect paralysis of the sphincters existed from the beginning, and any distension of the bladder occasioned severe abdominal pain. On the 14th of May, the integuments over the sacrum first became inflamed, and on the 21st the bladder had lost its power of distention, the urine flowing away as secreted. On the 31st of May a decided bed-sore made its appearance, which in spite of remedies gradually became worse. On the 15th of September several small pieces of necrosed bone came away from the sacrum, and from this time the patient's powers gradually gave way, and on the 25th of December, being nearly eight months after the accident, the man died.

On *post-mortem* examination, the body was observed to be wasted, and legs slightly œdematous. There was a sloughing bed-sore over sacrum, exposing necrosed bone, and the sacral canal, which admitted the passage of a probe.

No permission being given to inspect the body, the seat of injury was alone examined.

Externally, over the lower dorsal vertebræ some irregularity was observed, but the bones were quite firm; the muscles round the

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part were pale, but no signs of inflammatory products were detected in the soft parts.

On removing the lower dorsal and upper lumbar vertebræ, the mischief was clearly seen to have been produced by a dislocation of the eleventh dorsal vertebræ forwards, causing the twelfth and lower vertebræ to be projected backwards.

The separation had taken place at the inter-vertebral cartilage, and this had now almost entirely disappeared, a thin layer only remaining in parts; in others the bones were in contact, producing almost complete ankylosis. The eleventh vertebra, as a whole, seems to have been thrown forward for half an inch and downwards, rupturing all the ligaments confining it to the one below, and permitting a separation of the spinous processes to the extent of nearly one inch. The edge of the anterior and superior surface of the body of the twelfth was also broken off with the downward pressure. The lower lumbar vertebræ and sacrum were black and necrosed; the sacral canal was exposed, and the cord within of a dark green colour, and sloughing; this state of the medulla extended up into the lumbar region.

The cord at the seat of injury was compressed and disorganized, but both above and below it was healthy.

The above is a specimen of a class of cases, which have been generally regarded as somewhat rare; the majority of authors believe that fracture of the spine, the result of accident, is by far the most frequent occurrence, the toughness of the ligaments resisting what the bones break under.

That such an opinion is not altogether correct, this present specimen tends to prove, as a direct blow upon the spine was apparently followed by a dislocation, and not a fracture. Three other cases have occurred at Guy's Hospital within the last eighteen months, illustrating the same opinion. Two of pure dislocation of the lower cervical vertebræ (where dislocation certainly may generally be expected), and one of the upper dorsal, proving, at any rate, that such a result from accident is not a rarity.

Another point of interest in the case, is the fact of the dislocation having been partially reduced by extension and local pressure; the relief afforded by the operation being of a most marked character. Mr. T. Bryant, *6th of January*, 1857.

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6. *Fracture of the Neck of the Thigh-bone within the Capsule.*

M. H., æt. 60, a lunatic inmate of the asylum at Guy's Hospital, five years ago, when walking in the garden, fell and fractured her right thigh-bone. All the symptoms of fracture of the neck of the femur within the capsule were present, clearly indicating the character of the injury. A long splint was applied, but much difficulty was experienced from the restlessness of the patient, in preserving the leg in the right position. After some weeks' confinement, she was allowed to sit up, but her health soon began to fade, and she never walked again, and on the 30th of June she died, from pulmonary phthisis.

On examining the leg after death, it was found quite moveable, and in its natural position. The left thigh was firmly placed upon the pelvis, leading one to believe that this was the seat of the injury; and the mistake was only discovered upon removing the head of the bone.

On examining the head of the right femur, the character of the injury was revealed; a fracture of the neck had taken place, and had firmly united, by means of bone, fibrous tissue, and fibro-cartilage, as clearly perceived on microscopical examination.

On comparing the specimen with the corresponding head of the left thigh, it was clear, that a large portion (indeed nearly all) of the neck had been absorbed; this absorption probably having followed the inflammatory action which was produced by the injury.

In the head of the bone, a large deposit of new bone, of a dense character was observed, rendering it probable that its vascular supply was quite sufficient in itself to permit of the repair of injuries. Connected with this, an interesting point may be observed. At the spot only where the new inflammatory deposit had reached the articular surface of the bone, the cartilage had disappeared; the inflammatory action in the bony lamella having evidently interfered with the nutrition of the cartilage, which receives its principal supply of nourishment through it; thus permitting its degeneration, and subsequent absorption.

Mr. Thomas Bryant, *3rd of February*, 1857.

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7. *Partial Dislocation of the Lower Jaw from an Enlarged Tongue.*

By the constant and long continued pressure of an enlarged tongue, the condyles of the inferior maxilla have been partially dislocated from the glenoid cavities, so that this bone has been thrust obliquely downwards and forwards, *vide* Fig. 13. projecting about an inch beyond the upper jaw and forming a prominence be-

FIG. 13.

Represents the amount of dislocation as accurately obtained by means of casts.
The figure reduced one third.

neath the chin. By this means the face has become, as it were, elongated, which, together with a hypertrophous condition of the lower, and shortening of the upper lip, impart a strange and grotesque aspect to the countenance, especially when viewed in profile. The tongue, which undergoes considerable variation in form and size, being at times so swollen as to protrude from the mouth, was, when measured on the 4th of January 1857, three inches in width, by three-quarters of an inch in thickness, and deeply indented by the upper row of teeth; mastication was exceedingly

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difficult and painful, and power of utterance impaired. The history of the case is as follows :—

At seven years of age, being then in good health, J. S., whilst standing on a stool in a shop, fell, and struck her chin violently against the counter; it was severely contused, and her tongue protruding from the mouth at the time of the fall, a large portion was nearly severed by the teeth. She lost a good deal of blood, but surgical aid being promptly obtained, the parts were drawn together by sutures and she soon recovered from the effects of the accident. Henceforth, until her eighteenth year, she enjoyed an average state of health, when she was frightened by discovering a large spider on her dress, having always had a great horror of that insect; this occurred during the menstrual period; sudden and entire suppression followed, and notwithstanding continued and persevering treatment directed from time to time towards the restoration of this function it has never returned. Up to this period the catamenial discharges had appeared with due regularity. Soon after this event she began to suffer from occasional and violent pains in the head. At twenty years of age she was first observed to be affected with dulness of intellect, and strange fancies accompanied by listlessness, bodily inactivity, and general derangement of the nutritive functions: about the same time she suffered severe pain from a carious tooth, in the upper jaw on the the right side, which was extracted. To this succeeded distressing facial pains on the same side, which have continued with more or less frequency up to the present period. She now began to experience general weakness of the articulations of the upper and lower extremities. On one occasion the shoulder joint was dislocated by a slight accident; her walking was frequently impeded by the powerless state of her knees and ankles. This condition of the joints lasted for several years. At the age of thirty, the surface of the body became generally swollen, which after a time partially subsided; the swelling is now confined chiefly to the hands and face. It was at this period that the tongue began to enlarge, and in twelve months afterwards, an altered condition of the lower jaw was first observed; but not until a year since, after the extraction of a lower molar tooth on the right side, which

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was followed as in the former instance by severe facial pains, was the protrusion of the lower jaw so great, as seriously to impede mastication and the power of utterance.

About five years since she had a severe attack of ear-ache on the right side, terminating in otorrhœa. The latter still troubles her occasionally. Soon afterwards she had an epileptic seizure, which was speedily followed by symptoms of amaurosis, that ended in total blindness, about two years ago. Altogether she has had nine epileptic attacks up to the present time. It is now nearly three years since this patient first came under my notice. At that time her mental powers were in a very weakened state; she had severe facial pains, and the lower jaw was then only slightly protruded. The amaurosis was fast increasing, and she complained, that whenever she tried to read, or exerted her eyes in any way, "she saw spiders and horrid faces, which frightened her very much." Even in darkness she was haunted by these spectra; her face and hands were greatly swollen; skin of a dirty yellow hue, and her digestive organs deranged.

From the history of the case, and the complications it presented, there seemed little probability that the amaurosis, concerning which her friends and herself were most anxious, would be relieved by any special remedies, all of which, indeed, had hitherto failed. My attention was, therefore, principally directed to the state of her general health. After some weeks of treatment she was in certain respects better, but the amaurotic symptoms had rather increased than otherwise. From this time I saw her but rarely. Six weeks since I was sent for, in consequence of a severe epileptic attack, which had been preceded for six or seven days by a constant state of drowsiness and stupor. She had remained unconscious during forty-eight hours, and, at the time I saw her, was labouring under the same symptoms as those with which the attack had begun. They had already lasted some days; the bowels were obstinately costive, and were only relieved by full and repeated doses of croton oil. The lower jaw, which her mother told me had been much distorted during the fit, projected more than ever; the pains in the head and face, especially in the vicinity of the

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articulating surfaces of the jaw, were most distressing; the tongue was greatly swollen, and deeply furrowed by the upper teeth. In the hope of affording some alleviation to the facial pains, and fearing that, in the event of another fit, further displacement of the lower jaw might ensue, I determined on supporting it, by means of counter-pressure, this was effected by passing a strong vulcanised India-rubber band, twice doubled over the head, and crossing it over the most prominent part of the bone. In addition to this, an astringent lotion was to be frequently used to the tongue. It is now more than a fortnight since she has followed this plan. At my last visit, (on the 31st of January,) she told me she had derived great comfort from the band, although, at first, she could only keep it on for a short time. The preceding case is interesting, inasmuch as it affords an additional proof to that already given by Mr. C. Vasey, (in Vol. vi. p. 172 of the Society's "Transactions,") of the effect produced on the lower jaw, by the slow and long continued pressure of the tongue. In his case, however, the protrusion was occasioned by an altered condition of the alveolar processes, whilst, in this instance, as previously stated, the bone was thrust downwards and forwards, without any alteration whatever in its form or structure.

Mr. W. O. Chalk, *17th of February*, 1857.

Since writing the above, I have seen my patient again (on the 13th of February.) Her condition is a good deal altered for the better. The facial pains have subsided; the tongue is smaller, impress of the teeth scarcely visible, and the projection of the lower jaw lessened.

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8. *Complete Separation of the Fifth and Sixth Cervical Vertebræ from Injury.*

The specimen was taken from the body of a man, æt. 33, who was admitted into St. George's Hospital on the 26th of September, 1853, under the care of Mr. Tatum. A short time previous to his admission, he had fallen head foremost, a height of about fourteen feet. There were all the usual symptoms of fracture of the spine, high up. He had lost all power of motion and sensation in the extremities and trunk, the

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bladder was paralyzed, and priapism followed the introduction of the catheter. The water was natural in appearance and reaction, the temperature of the body not remarkably different from the healthy standard; consciousness perfect. On passing the hand down the spine a considerable hiatus was felt in the row of spinous processes towards the root of the neck, where the injury evidently existed. He slept a little that night, and next day was found quite tranquil and collected, with little trouble in the breathing which was entirely diaphragmatic, and no pain anywhere. He held his hand in a peculiar position, like that assumed by a child with diseased cervical vertebræ, and did not move it at all. There was slight sensation in the arms, but no power of motion. The bowels had not been open—the other symptoms remained the same. Towards the evening of the 27th, he became rapidly worse, the breathing much oppressed, and he complained of difficulty in swallowing. From this time he rapidly sank, and died on the following morning, (about forty hours after the accident).

The *post-mortem* examination was made twenty-nine hours after death. The body was well formed and in good condition.

Spine.—Much blood was extravasated in the areolar tissue and muscles of the cervical portion of the spine. On removing the muscles from the vertebral grooves, there was found to be almost complete separation of the fifth from the sixth cervical vertebræ. The ligamenta subflava were torn through, and the contiguous articulating surfaces exposed and separated from one another; the inter-articular disc between the bodies of the vertebræ was lacerated, and the anterior and posterior common ligaments torn completely across. The lateral ligaments were entire. The dura mater was torn, and the central part of the cord lacerated, soft, and infiltrated with much recently extravasated blood. The body of the fifth cervical vertebra was displaced forwards on a level more anterior than that of the sixth, so that the posterior edge of the body of the latter encroached upon the spinal canal.

Thorax.—There were numerous adhesions between the pleuræ on the left side of the chest of very old standing. The lungs were much congested, and the back parts of both lobes on either side, very œdematous. The heart was healthy.

Abdomen.—The intestines were distened with flatus. The

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liver was healthy. The spleen was large and soft in texture. Both kidneys were very much congested.

Mr. Henry Gray, *3rd of March*, 1857.

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9. *Chronic Rheumatic Arthritis of the Hip-joint.*

The specimen was removed from a male subject, in the dissecting room of the Westminster Hospital. The age of the subject was 71, and the only history that can be obtained is, that he had been bed-ridden for four years, but had complained of rheumatic pain in the right hip for years previously. The cavity of the affected acetabulum was enlarged, but less so in reality than appeared at first sight, since some considerable part of the cavity was formed by a peculiar arrangement of the circumferential ligament. The articular cartilage was absent from half the bony surface, which was eburnated and had lost the usual bony markings found in the joint. There was no trace of Haversian gland or round ligament, and the surface of bone about the notch was eroded.

The circumferential ligament was almost wanting at the inner part of the acetabulum, but at the outer part it was much thickened and flattened, and semi-cartilaginous; at the upper part the ligament was entirely wanting, but was replaced by a nodulated mass of bone projecting from the upper margin of the cavity, and thus deepening it in that direction. A smaller process of bone was also contained in the capsular ligament at the upper and outer part. The bone around the joint appeared to be thickened in some places.

The head of the femur was considerably enlarged, more especially on its anterior surface, which was prolonged towards the great trochanter, there being a process of new bone connecting the head with that process. The circumference of the articular surface projected beyond the line of the head of the bone in the rest of its circumference. There were no remains of the ligamentum teres, and roughened cartilage was present on all the circumference of the articulating surface, but in the centre it was wanting and the bone was eburnated. The other joints of the body were affected but in a very trifling degree.

Mr. Christopher Heath, *17th of March*, 1857.

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10. *Two Cases of Caries of the Head of the Tibia.*

Case 1.—An aged looking man, æt. 55, was admitted into Guy's Hospital, under Mr. Birkett, in April, 1855. He complained of great pain in the head of the right tibia, and there were fistulous openings and sinuses leading to carious bone. The disease commenced five months before with pain which was all referred to the knee-joint.

On the 24th of April the sinuses were laid open. Mr. Birkett gouged out a large quantity of carious cancellated tissue from the head of the tibia. It was observed that there was no circumscribed collection of pus, but that the cancelli were full of this deposit. There was no detached mass of necrosed bone. A sinus extended through the bone into the popliteal space. A large cavity existed after the operation, but the wound nearly healed and the man was relieved from great pain.

In February, 1856, nearly ten months after the operation, he again entered the Hospital. The wound had never healed, the cavity in the head of the bone had not filled up, and the odour of the discharge from it clearly indicated the presence of more diseased bone. With a view to the removal of this disease he was re-admitted, but after he had been in the Hospital a few days, he was seized with violent constitutional disturbance, followed by intense depression and death. The knee-joint became, at the onset, violently inflamed, and no relief was afforded by the treatment adopted.

It was discovered, *post-mortem*, that the knee-joint was filled with pus; and at the attachment of the posterior cornu of the internal semilunar cartilage there was a small hole, by means of which, a communication was established between the joint and the cavity in the head of the tibia. The macerated and dried head of the tibia was exhibited with a large cavity; in fact, merely a shell of the head of the bone remained. The opening was very well marked, which established the communication above described. There are two ways in which the suppuration of the joint may have been established.

1.—By the pus from the cavities in the carious bone, ulcerating posteriorly into the articular capsule of the knee-joint and there exciting inflammation; or,

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2.—Pus may have traversed the cancellated tissue of the bone, until, reaching the articular lamella of the head of the tibia it may have penetrated and burst at once into the joint. The state of the parts would not permit a positive conclusion being stated. This case sufficiently demonstrates the danger in which the life of a patient is placed by the existence of a large carious cavity in the articular ends of bones.

Case 2.—A man, æt. 27, who from his cachectic and worn appearance might have been taken for fifty, was admitted in July, 1856, into Guy's Hospital, under Mr. Birkett. His occupation was that of a sailor, but he had been engaged in the Crimea, and was in Hospital at Renkioi.

Four months before admission he was seized with pain in the left knee; abscess formed over the head of the left tibia, broke, and through the opening carious bone could be felt. The knee joint was semiflexed and painful on movement. In the hope of removing all the dead bone the sinuses were opened, but portions only could be taken away. About December, he was attacked with acute albuminuria, and became greatly reduced. Much dead bone could be felt, in fact, the entire head of the tibia seemed to be diseased. Seeing no chance of curing the case, amputation was advised and consented to by the patient immediately. His health was improved, the urine free from albumen, and on the 10th of March, the limb was amputated through the lower third of the femur.

The articular cartilage upon the head of the tibia was only loosely attached to that bone, and there was slight erosion of the articular cartilage upon the condyles of the femur. But in the joint itself, the disease was not sufficiently advanced to demand amputation. The whole of the head of the tibia was diseased, a large mass of it having necrosed, and the surrounding cancellous tissue being carious. There was pus in the cancelli and about the soft parts, and the upper part of the shaft of the tibia was unhealthy. The line of union between the epiphysis and the shaft was traceable, and the disease had commenced in the former. Amputation was performed in this case, fearing a similar result to that which occurred in the first, and it appears evident

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that had not the disease been removed, the joint would have become very speedily involved.

Mr. J. Birkett, 17*th of March*, 1857.

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11. *Impacted Fracture of the Neck of the Thigh Bone.*

This specimen was sent to me by my friend, Mr. W. Hills, of the Kent County Lunatic Asylum, with the following history:—

A. C., æt. 66, on the 16th of February, 1853, fell accidentally in the ward, and injured her right hip. There was about one inch and a half of shortening, which could not be diminished by extension, and no crepitus, thus leading the surgeon, at first, to believe that a dislocation was the form of injury.

The limb was put upon a long splint, and the patient confined to bed for six weeks. Subsequently, she gradually regained strength in the limb, and was able to walk without assistance. The shortening however, still persisted. On the 30th of July, 1854, seventeen months after the accident, she died from acute bronchitis.

This specimen is a good example of the impacted fracture of the neck of the thigh-bone, so well described by Mr. Smith, of Dublin. The neck has evidently been driven into the bone, for more than one inch, the direction of the cancelli of the bone indicating the extent. The major trochanter, as is usual, was also fractured. The symptoms during life clearly pointed to the character of the injury, which the specimen itself well demonstrates.

Mr. Thomas Bryant, 7*th of April*, 1857.

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12. *Syphilitic Necrosis of the Femur.*

When syphilis attacks the bones, it usually causes only the death of superficial portions, resulting in exfoliations. The present case, however, affords an example of a much more rare occurrence, and one which has been but little adverted to by authors; namely, the death of the whole shaft of a long bone. The patient, a man, æt. 23, was under my care in the Metropolitan Free Hospital. Eighteen months before admission he began to complain of severe pain in the left thigh, and was

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confined to bed for six months in another Hospital, on account of it. At length, abscesses formed, and broke in several places, leaving fistulæ. On admission, the whole femur, from a little below the trochanter to the knee, was enormously thickened; indeed the thigh had nearly twice the girth of the opposite one. In operating, a free incision was made along the outer side, and a trephine with a large crown applied in two places, the intervening bridge of bone being removed by the saw. The substitute shell was very complete, and had a thickness of nearly an inch, being also very dense and firm. The sequestrum was easily removed, as it broke up into fragments when twisted forcibly. In small fragments what appeared to be almost the whole length of the shaft of the bone, was taken away, leaving a large cavity lined by soft granulations. The evidence that the necrosis had really been syphilitic, was that the man had a node on the tibia of the same leg, which was liable to much nocturnal pain, and that he had had primary disease about three years ago. Mr. Hutchinson stated that he had seen several well-marked examples of syphilitic necrosis of the shafts of long bones, and had observed, as a distinguishing feature in their course, that the inflammation causing the necrosis was always chronic and slow in its progress, differing most markedly from the acute periostitis which usually causes that result.

Mr. Hutchinson, *5th of May*, 1857.

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13. *Ankylosis between the Occiput and the Cervical Vertebræ, &c.*

The specimen, which was a dried one, consisted of the chief part of the occipital bone, and the four upper cervical vertebræ. The first cervical vertebra was intimately, and almost at all parts of its upper surface united to the occipital bone, along the margin of the foramen magnum.* Owing to the union of the laminæ of the vertebra to the occiput, the inferior articulating surfaces were inclined backwards to a very considerable extent. Moreover, new bone was deposited about these articulating processes and specially

* Dr. Ogle remembered to have been told some years ago by the late Mr. Alexandre, the Dealer in Skeletons, that more or less complete bony union between the occiput and the first cervical vertebra had been found by him in one skeleton out of every two hundred which he had to prepare for sale.

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about the right one, whose surface was also increased much in size, polished, and at the same time porous. The lamina of this vertebra on the right side posteriorly, was wanting to a slight degree, so that the posterior arch naturally produced by the two laminæ, was broken just on the right side of the tubercle; new bone had been thrown out at the posterior surface of the anterior arch of the bone.

The three other vertebræ were completely welded together, as it were, their articulating surfaces being quite united to each other, new bone having been thrown out between the various laminæ so as to convert the spinal canal at this part, almost into a complete bony cylinder. This canal was very much curved, owing to the bending forward of the two upper cervical vertebræ. The superior articulating surface of the second cervical vertebra on the right side, like the corresponding one on the first vertebra, was increased in size by the deposition of new bone, and was polished and porous. The odontoid process was very much thickened by new bone, specially at its summit and anterior surface, and new bone was also thrown out on the anterior surface of the third and fourth vertebræ. How far down the spinal column ankylosis of the vertebræ existed was not known. Thus there was no motion observed between any of the vertebræ excepting between the atlas and the axis; and on joining the bones together at this articulation, it was found that, owing to the oblique inclination of the articulating surfaces, the spinous process of the second vertebræ which was largely developed, all but rested upon the posterior or under surface of the occiput. All the bony prominences at the posterior surface of this bone, moreover, were very largely developed for muscular attachments, and specially was this the case at the inferior curved ridge, on either side of the middle line, where actual pointed projections of some length were formed; that on the right side being as much as half an inch in length, sharp at its edges and flattened from before backwards. All the bony ridges also on the inner surface of the occiput were remarkably developed. It was worthy of notice, that on joining the atlas and axis together and rotating them, the large bony prominence on the right side of the occiput, just mentioned, touched the spinous process of the second cervical vertebra, so that during life, when clothed by

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muscle &c., it must have greatly limited the movement of rotation, and in this way may have afforded a natural provision, to some extent, against certain motions rendered dangerous or painful by the disease of the articulating surfaces of the vertebræ. When recent, the odontoid process of the cervical vertebra was so increased in size by the deposition of calcareous particles in a tough fibrinous material, as quite to block up two-thirds of the foramen magnum. This material was lost in maceration.

History.—The history, as supplied by Mr. Hussey, of Oxford, to whom Dr. Ogle was indebted for the preparation, was as follows:—

The person from whom this specimen was removed, was a man, æt. 73, who had worked as a tailor for many years of his life. For a long time he had been insane and unfit for work, and he had talipes varus of both feet, which was said by friends to have been congenital, but the statement appeared doubtful. The knees and hips were contracted, and could not be straightened, although there remained the power of flexing them; and the patient's usual mode of progression was on his rump, with his legs crossed like a tailor. He could kneel on a bench, but could not in this way raise himself up. The arms were also slightly contracted at the elbows, as were the fingers, especially the ring and little fingers. The contraction of the arms, which was less than that of the legs, and had come on later in life, had been increasing for some time before the patient's death; but he could flex them at will, though he could not extend them. He used to grasp things firmly with his hands.

The patient was of an active, timid, disposition, and much given to turning his head round, as if from fear of something coming near him. Did this signify any increased sensibility? It was, however, not observed during life. He had had gout several times, but never anything like epilepsy, or fits of any kind, and about his body were no traces of any strumous affection. He died of fever.

On *post-mortem* examination, in addition to the morbid appearances furnished by the specimen, emphysema of the lungs was found, and also slightly increased fluid in the lateral ventricles of the brain, with some fulness of the meningeal vessels; but other-

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wise the viscera were natural in appearance. The spinal cord was not examined.

The specimen above described is now placed in the Anatomical Museum of Christ Church College, Oxford.

Dr. JOHN OGLE for Mr. HUSSEY, *5th of May*, 1857.

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14. *Puerperal Osteophyte in the Calvaria.*

The specimen was exhibited as an apparent example of the so-called "puerperal osteophyte," which is stated by Rokitansky to occur in pregnant women, as a new layer of bone, covering the inner surface of the skull. This pathologist says, that in a considerable number of females who have died during the period of gestation, he has found a deposit of new bone in various portions of the cranium, particularly along the course of the longitudinal sinus, the furrows for the meningeal artery, and also as patches on the base. As early as the third month he has seen it as a soft exudation on the internal table, subsequently harder and cartilaginous, and at a still later period, as a lamina of true osseous substance on the parts before-mentioned. From the fact of such irregularities on the surface of the skull being so common, considerable scepticism is naturally felt with regard to the remarkable statement of the German pathologist. It having, however, never been refuted, the present specimen was brought forward, in order, especially, to gain the opinion of the Society respecting it.* The calvaria came from a woman twenty-six years of age, who died at the sixth month of pregnancy, having previously borne one child, and, on examining its interior, the surface, especially in the parts above indicated, presented a new layer of bone. This was smooth and white, and was evidently of new formation. There were also small nodules of bone in some other places. The general appearance, in fact, coincided with the description given by Rokitansky.

Dr. S. WILKS, *9th of May*, 1857.

* Several members of the Society observed that they had watched for similar bony growths on the calvaria, in connection with the puerperal condition, but had never been so fortunate as to meet with them.—ED.

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VII. DISEASES, ETC., OF THE ORGANS OF SPECIAL SENSE.

1. *Melanotic Tumour growing from the outside of the Eye-ball.*

W. H., a healthy looking man, æt. 48, a labourer, was admitted into the London Hospital on the 2nd of December, 1856, on account of a formidable tumour, and projection of the right eye. He stated, that about eighteen years ago he lost the sight of the right eye, being, at the same time, a patient at the Royal Ophthalmic Hospital. The present disease commenced about four months previous to his admission. There was a considerable tumour projecting and separating the eyelids, the eye being nearly in the centre, and appearing somewhat flattened, and the cornea dull. The conjunctiva was red and vascular, and the eyelids tumid and congested. The appearances seemed to indicate serious disease, affecting the interior of the globe. The patient complained of pain in the head, which interfered with his rest at night. The globe was excised on the 4th. The divided vessels bled freely. The hæmorrhage was arrested by the free application of the actual cautery. The orbit was afterwards plugged. The man lost the pain in the head, and recovered favourably from the operation.

On making a section of the tumour through the eye-ball, I observed a melanotic mass about half an inch in thickness on the outside of the globe, but closely connected with the posterior half of the sclerotic. This part of the sclerotic was much thinned, and, at the extremities of the tumour, was split, as if the morbid growth had been developed originally between its layers. The optic nerve was nearly surrounded by melanosis, and near the eye was compressed, and partially atrophied by the morbid growth. The lens was opaque, and of a mahogany hue. The tumour was composed of distinct masses of different shades of black, and a loose portion, prolonged from its back part, must have been seated deep in the orbit. In the microscope, the appearances were indicative of cancer.

When melanosis attacks the eye, it commonly commences in the interior of the organ, and I know of no recorded case, in

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which either this disease or medullary cancer had sprung from the outside of the sclerotic, and formed a considerable tumour, without further implicating the globe, as in this instance.

Mr. Curling, *6th of January*, 1857.

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2. *Separation of the Retina and Choroid by a Firm Fibrous Substance, in part converted into true Bone.*

The eye is said to have been the seat of choroido-retinitis. The globe was small, hard, and irregularly puckered on its surface. The cornea was clear. The pupil was widely dilated, the iris appearing as a narrow ring; its anterior surface bright, and there were no adhesions. The lens opaque. The thickness of the sclerotic varied very greatly, Plate VII. Figs. 1, 2. The choroid was everywhere closely adherent to the sclerotic, and shewed, in some places, a want of pigment.

The retina, separated from the choroid, had assumed the form of a wine-glass, Fig. 3; its narrow stem was fixed behind, at the entrance of the optic nerve, whilst in front it suddenly expanded as a shallow cup which was attached marginally in the ciliary region. This shallow cup of retina contained a small quantity of vitreous humour, natural in appearance and consistence, but which did not solidify in chromic acid.

The natural structures of the retina had disappeared. The hyaloid membrane variously folded, was coated with granular *debris*, in which, however, the long meshes of the retinal capillaries could be traced. In the space between the retina and choroid there was a firm fibrous mass which was pierced by the narrow stem of the retina running backwards. Posteriorly, its outer surface was converted into a thin cup of true bone, Figs. 2,3,4, and a like change had taken place in front in the angle of separation of the retina and choroid. In parts the fibrous mass had a pink tinge, and it also contained two small irregular cavities filled with brownish serum, in which withered blood-discs and cholestearine-plates were suspended.

Mr. Hulke, *20th of January*, 1857.

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3. *Thin Cup of Bone on the Inner Surface of the Choroid.*

Nothing is known of the previous history of this case. The bone forms a thin cribriform shell, lining the whole inner surface of the choroid, pierced behind at the entrance of the optic nerve, and reaching forwards to the ciliary region. The choroid, in which there are numerous crystals of oxalate of lime, Plate VII. Fig. 6, can be readily traced over the outer surface of the bone, and a small band of retina, which remains attached to the entrance of the optic nerve, but elsewhere is free. This is an old preparation, which has been put up several years.

These two cases are instances of the formation of true bone, as distinguished from mere calcification, in the human eye.

I think there has first been an effusion of plastic lymph on the inner surface of the choroid detaching the retina, and thrusting it, at the expense of the wasting vitreous humour, towards the axis of the globe. This lymph has been organized into fibrous tissue, and the latter has subsequently been converted into true bone with vascular canals and lacunæ, &c., Plate VII., Fig. 5.

Having carefully considered many recorded examples of ossification of the choroid, of the retina, of the hyaloid membrane, and the vitreous humour, I am led to believe that the above explanation will hold good in most of these instances; *viz.*, that they are ossifications of exudations between the choroid and retina. I think this is clearly the case with regard to a specimen exhibited by Dr. Taylor for Dr. Kirk, and recorded in Vol. vi. of the "Transactions," p. 300, and Plate XIII. Fig. 2.

Mr. Hulke, *20th of January*, 1857.

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4. *Melanosis of the Eye-ball.*

A. G., twenty years ago lost the right eye by violent inflammation, which was followed by shrinking of the globe. This eye has since been subject to repeated inflammatory attacks. Two months before his admission into King's College Hospital, the conjunctiva became red, and soon two small tubercles appeared on the front of the eye; these burst, and discharged a bloody serum. Shortly afterwards a tumour shot out, and has

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DESCRIPTION OF PLATE VII.

Figures 1 to 4 illustrate Mr. Hulke's case of Fibrous Deposit between the Choroid and the Retina, partially ossified, p. 319.

Fig. 1. Transverse section of the eye-ball.

A. Retina.

B. Fibrous mass.

C. Cavities.

Fig. 2. Longitudinal section of the posterior half.

A. Retina.

B. Fibrous mass.

C. Sclerotic.

D. Choroid.

E. Bone.

Fig. 3. Longitudinal section of the globe (diagram). The same letters indicate the same parts as in Fig. 2.

Fig. 4. Magnified representation of a portion of the abnormal bone.

Figures 5 and 6 illustrate Mr. Hulke's case of a Thin Cup of Bone on the Inner Surface of the Choroid, p. 320.

Fig. 5. Haversian canal in section, and bone lacunæ.

Fig. 6. Choroid with octahedral crystals of oxalate of lime.

Figure 7 illustrates the Microscopic Structure of the Deposit, in Mr. Hulke's case of Melanosis of the Eye, p. 320.

Figure 8 represents the Microscopic Elements in Mr. Hulke's case of Melanosis in the Choroid, p. 324.

A. Large rounded cells filled with pigment.

B. Large fusiform and caudate cells seldom containing pigment.

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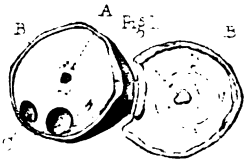

Fig 1.

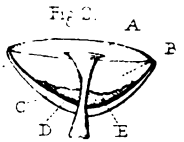

Fig 2.

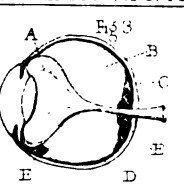

Fig 3

Fig 4

Fig 5

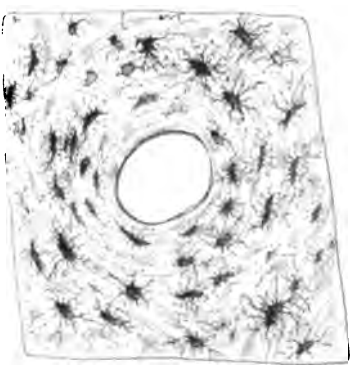

Fig 6.

Fig 7

Fig 8

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since rapidly increased in size. It projected considerably between the lids, stretching them greatly, and everting the upper lid. The surface of the tumour was irregular, dark coloured, and had a thin sanies oozing from it. The eye-ball was extirpated by Mr. Bowman; its interior was filled with a solid mass, which was continuous in front with the external fungous mass, the cornea being absent. The sclerotic coat had given way behind the insertion of the inner rectus muscle, and the cancerous growth protruded into the orbit; posteriorly also, near the optic nerve, there were some small nodules, which were continuous through apertures in the sclerotic, with the mass within the globe.

This cancerous growth consists of two portions, one deep black, the other grey. However widely different they appear to the unaided eye, their minute structures are nearly identical; the only difference being the presence of pigment in the dark, and the absence of it in the lighter portion. Both portions consisted almost wholly of large cells, the prevalent forms being fusiform and circular, and containing one, two, or three nuclei, Plate VII. Fig. 7. The circular cells were most numerous in the grey portion of the tumour; the fusiform in the darker parts. In the ciliary region there was a small bit of true bone, shewing lacunæ and vascular canals. The choroid could be traced upon the inner surface of the sclerotic, but no traces of the retina were found. The optic nerve, though healthy to the unaided eye, was seen, under the microscope, to be infiltrated with cells similar to those in the grey portion of the tumour.

This case illustrates the liability of an already disorganized eye to subsequent repeated attacks of inflammation, and it is also interesting to observe, at how late a period in the history of the case, melanosis was developed—nineteen years after the first inflammatory attack. It shews another point too, *viz.*, that the power the patient had of moving the prominent tumour was not a certain sign that the sclerotic was entire posteriorly, and the cancerous growth confined to the interior of the globe in this situation.

Mr. J. W. Hulke, *17th of February*, 1857.

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5. *Encephaloid Cancer of the Eye-ball.*

The patient was a child of about four years old. The growth had been watched for several months. It gave the usual bright reflex; at first it seemed deep-seated, and gradually advanced to the posterior surface of the lens. Blood-vessels were clearly seen ramifying upon the bright yellow surface. The eye having become inflamed, was removed by Mr. Bowman.

The situation of the vitreous tumour was occupied by a soft brain-like mass, which was very vascular. Scattered through it were numerous opaque, white, mortar-like grains. The minute structures were those of medullary cancer, the white portions being in a state of atrophy. The choroid could be traced enveloping the cancerous growth; but between the choroid and sclerotic was a thin pink layer of organizing lymph, of a gelatinous-consistence. The choroid itself was thickened, and its tissues were infiltrated with exudation cells. The ciliary muscle was remarkably thick, and its vascularity greatly increased, giving it a deep-red fleshy appearance. The thickening was due to inflammatory exudation. The lens was opaque. The pupil dilated.

Mr. J. W. Hulke, *17th of February*, 1857.

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6. *Accumulation of Mucus in the Tympanum of the Ear.*

The specimens are the petrous bones of a male child, æt. 19 months, who died on the 26th of March, after a convulsive attack of twelve hours duration.

The history could not be very clearly ascertained, but it appears that about Christmas, while in the country, he had an attack of pain in the ears which caused him to cry a good deal for two or three days; this was followed by a discharge from the right ear, which however, soon subsided. Since that time he had been in the habit of putting up his hands and rubbing round his ears, but had not seemed to be in pain, nor had he been noticed to be deaf. About ten days before his death he became poorly, with cough and restlessness, and at first some tendency to vomit, but he was not supposed to be seriously ill, nor was

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medical attendance obtained for him. On the day before his death he seemed better and was taken for a walk, but he was suddenly seized with convulsions in the evening.

On examination, thirty-six hours after death, the sinuses of the dura mater were found full of blood, and the arachnoid of a pinkish colour. The brain was very firm; there was no unusual amount of fluid in the ventricles. In the situation of the olivary bodies there was a small point of extravasation of blood with slight softening of the nervous substance around it. The bronchial mucous membrane was reddened, and the tubes contained a little mucus; the right side of the heart contained some decolorised clots. The cavity of the tympanum on each side was filled with a tenacious semi-fluid substance, which did not escape through the Eustachian tubes. The mucous membrane was red and very much thickened, and the bone forming the wall of the tympanum easily separated from it, so that portions of the bone might be removed, leaving the membrane still bounding the cavity.

The membranæ tympani were opaque, drawn in, and presented the peculiar mottled appearance characteristic of a thickened and congested condition of the mucous layer, as seen through the external laminæ of the membrane, which being comparatively free from disease retain nearly their normal transparency. The labyrinth was healthy on each side.

Mr. James Hinton, *7th of April*, 1857.

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7. *Malignant Disease of the Eye-ball.*

The patient was a female, æt. 32. During the last eleven years she had had, occasionally, neuralgic pains and temporary loss of vision in the right eye. A year before her admission into the Royal London Ophthalmic Hospital, under Mr. Bowman, her sight began permanently to fail; and, six weeks ago, all sight in this eye was entirely lost. During the last month she has suffered great pain in the eye.

The lens and humours being clear, a vascular growth was readily seen, occupying the bottom of the globe, and, on the inner side reaching forward nearly to the back of the lens.

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With the unaided eye, vessels were seen upon the surface of the tumour, and with the ophthalmoscope, these vessels were found to consist of two sets; a slender set of vessels, having the arrangement and arborization of retinal vessels, and a deeper posterior set, larger in size, belonging to the morbid growth, and appearing at various points on its surface. The presence and arrangement of the vessels not merely enabled it to be distinguished from a strumous deposit, but also indicated its exact position, *viz.*, behind the retina.

The eye having been removed by Mr. Bowman, and a section made from front to back, an encephaloid growth was found exactly corresponding in situation and appearance with what had been observed with the ophthalmoscope. The growth developed in the choroid had split it into two layers which completely enveloped it, and had carried before it the retina, which closely adhered to the choroid, clothing the anterior surface of the growth. The minute structures were those of encephaloid cancer, in parts, however, approaching a melanotic character.

Mr. J. W. Hulke, *7th of April*, 1857.

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8. *Melanosis of the Eye-ball.*

H., a gentleman, æt. about 46, sought in April, Mr. Bowman's advice, for what he had been informed was glaucoma of the right eye. On the outer side of the globe there was a very remarkable cluster of larger tortuous veins; pupil large; slight perception of light. With the ophthalmoscope a vascular tumour was discovered in the lower and outer part of the globe. No doubt existing as to the malignant nature of the disease, Mr. Bowman removed the eye by the operation he has for some years past usually performed, *viz.*, within Bonnett's or O'Forral's capsular fascia.

A section of the globe shewed a melanotic growth in the outer and lower part of the globe, reaching from near the entrance of the optic nerve forwards, to the ciliary region, and corresponding to the dilated veins on the outside of the globe. The retina was carried forwards upon the surface of the tumour, but was not implicated in it; elsewhere the retina and choroid

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were separated by a grumous fluid. The growth was confined to the globe, and did not involve the optic nerve. It appeared to have its origin in the choroid, and its minute structures consisted of:—1. Large, more or less circular cells, highly charged with rich brown pigment. 2. Large fusiform and caudate cells, with very long processes, and mostly without pigment. 3. Free nuclei and granules in abundance, Plate VII. Fig. 8.

In this, as in a former case I exhibited, the ophthalmoscope instantly revealed the true nature of the disease, the diagnosis being based on the appearance of the vessels of the morbid growth.

Mr. J. W. Hulke, *21st of April*, 1857.

VIII. DISEASES, ETC., OF THE SUPRA-RENAL CAPSULES.

1. *Disease of the Supra-renal Capsules, with Entire Destruction of their Proper Texture.—Bronzed Skin, well marked.*

J. L. æt. 18, was admitted into St. Bartholomew's Hospital, under the care of Dr. Baly, on the 5th of September, 1856. He presented in a very marked degree, the yellow-brown hue of the skin of the whole body, which is known as the bronze complexion. It was the more remarkable in him from his hair being of a very light-brown colour. At the epigastrium, where a blister had been applied a twelvemonth previously, the colour of the skin was darker than elsewhere, and on the legs there was the well-known mottled appearance.

The expression of his countenance was heavy and rather suffering. The skin was warm and moist; the tongue dry, and brownish down the middle, and moist, with a thin whitish fur at the sides; pulse, one hundred and six, small and soft; respirations twenty-eight, deep and rather laboured. He complained of a constant heavy pain in the head, of a sharper pain in the loins, where there was decided tenderness on pressure; of great thirst; of complete loss of appetite, and of constant drowsiness. His bowels were opened easily by castor

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oil, and his urine, of specific gravity 1·018, was rather high-coloured, but clear and free from albumen. His parents died when he was very young. An only brother has good health.

History.—He had been twice before a patient in St. Bartholomew's Hospital, under the care of Dr. Burrows. He was first admitted in October, 1855; was then a baker at Mile End, and was of temperate habits; with the exception of occasional headache, had enjoyed good health; and had been recently attacked with severe headache, pains in the limbs, loss of appetite, languor and debility. The dark colour of his skin, which was then present, had existed for a long period; but he knew that his complexion had undergone a change. He was discharged at the end of November, free from all sense of illness, and with a decidedly less dark colour of the skin. He was re-admitted on the 18th of May, 1856. In the interval, he had become a shoemaker, had lived well, but temperately, and had enjoyed good health until within the last three weeks, when he had been seized with a sharp pain in the loins, first felt only on the right side, and intermittent, but afterwards felt on both sides and constantly, with which, as before, complete loss of appetite and great languor were conjoined. The bronze colour of the skin was now deeper; and the deepening of the tint, he said, had been co-incident with the return of the pain and other symptoms. While he was in the Hospital on this second occasion the chief features of his illness were, pain and tenderness on deep pressure, to the right of the umbilicus and in the right lumbar region, headache, delirium on several nights, great thirst and loss of appetite, vomiting of food, a soft and even retracted abdomen, extreme listlessness of manner with frequent yawning; at one time great depression, with a small, feeble, and slow pulse, and, lastly, a peculiar odour of the skin. These symptoms continued until the end of May, when they rapidly subsided, and the bronze tint of his skin became somewhat lighter. He regained flesh and strength, and was discharged on the 30th of June. He remained well until three weeks before his re-admission on the 5th of September.

His present illness, like the preceding one, began with pain

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in the head and back, which had gradually become more urgent. But the bronze hue of his skin had begun, he said, to deepen a fortnight previously. Four days before his re-admission into the Hospital, he had a rigor which was followed by drowsiness.

After his admission, no marked change took place in his condition, from the 5th to the 16th of September. On the 10th and 11th, his mind seemed less oppressed, and he took food better. But this improvement was only temporary. The chief symptoms which he presented were the same as in his former illness. The torpid state of mind was, however, more marked, the yawning more frequent, the vomiting more urgent; there was some accumulation of sordes about the teeth and lips; the gums were congested and bleeding; the tongue had a thicker brown fur, and the pulse was more feeble. The abdomen, as before, became flat and empty; it was generally sensitive to pressure, and there was pain and tenderness, especially in the left hypochondrium. There was a tendency to diarrhœa; while, in the former illness, the bowels were rather costive.

On the 17th his hands and feet became cold. His pulse was ninety-four, very feeble, and his urine was found to contain much albumen, from which it had previously been free.

On the morning of the 18th, he was evidently much weaker; vomiting of bilious matters was almost constant, and his urine was again found to be loaded with albumen; its specific gravity was 1·022. About mid-day he suddenly sat up in bed, and said he could not see. His pupils were widely dilated. He began to breathe in a laboured manner, while he threw himself about the bed, then became unconscious of sounds, and, in half an hour, was dead.

The examination of the body was made on the 19th of September, twenty-six hours after death. The whole surface of the body was of the same bronze tint observed during life. The darkest parts were, first, the scrotum and penis, and, after them, the areolæ of the nipples, the anterior surface of the neck, and the parts of the abdomen where blisters had been applied. In a section of the skin it was seen that its deeper layers were of the natural colour. (The microscopic examination of it has been made and will be found described by Mr. Hutchinson, Plate VI. Fig. 4.)

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All the tissues of the body were unusually dry. The fat of the abdominal cavity had a peculiar slatey tint. The brain and its membranes were healthy. The thymus gland was rather large. The left pleura was adherent throughout. The bronchial glands were rather large, but free from abnormal deposit. The lower lobe of the right lung contained much dark blood; and at its posterior surface there was discovered a small, firm mass, not larger than a grain of pearl barley, which was composed, apparently, of four or five minute grey tubercles, with white, opaque centres. The lower lobe of the left lung had one still smaller mass of the same kind; otherwise, the lungs were quite healthy. The pericardium was healthy. The blood in the heart was partially coagulated; the cavities and muscular walls of the heart normal; the valves healthy, except that the right and posterior aortic valves were united to a small extent.

The stomach and intestines were free from disease. The liver, of normal size, had an uniform deep purple tint, with no trace of yellow or brown colour, except in sections at the points where the bile-ducts had been divided; it was full of blood, and when this had drained away from it, it presented a more natural colour. The gall-bladder contained bile of a greenish, orange tint. The spleen was not enlarged, but was soft, and its Malpighian corpuscles were remarkably distinct, large and numerous.

The kidneys were much congested, but otherwise healthy.

Both supra-renal capsules were of less than normal dimensions, being especially narrower than they are in the healthy state. Their surface was nodulated, and generally of a yellow colour, which was, however, concealed in parts by the thickened and opaque condition of their investing membrane. They are very firm, or even hard to the touch, especially the projecting nodules, and, when cut, their proper structure was seen to be entirely lost.

The right supra-renal capsule was most diminished in size, and most nodulated. It was composed of a very firm, grey, semi-transparent, substance, like cartilage or fibro-cartilage, and a yellow, opaque, brittle substance, less firm in part which occupied the centre sof the nodules, but, in parts, reached their surface.

In the left supra-renal capsule, very little of the semi-trans-

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parent, greyish substance remained; nearly the whole mass was composed of the yellow, opaque substance, which, in some parts was very firm, in others brittle, and in others again, dry, hard, and calcareous; while, at the lower extremity of the body, there was a cavity of the size of a small pea, filled with opaque, greenish-yellow, semi-liquid matter.

On *microscopic examination*, both the grey, semi-transparent, and the yellow, opaque portion of the diseased mass, presented the same elements, namely, a structureless substance, numerous oblong corpuscles, like nuclei, and minute fibrils, some of which were nucleated.

Remarks.—This case affords strong confirmation of Dr. Addison's views regarding the cause of the bronze-discoloration of the skin. The patient was three times in the Hospital, and, on each occasion, the peculiar complexion was recognized, and the diagnosis of renal-capsule disease founded on it. This peculiar complexion was of comparatively recent origin, and it became deeper and deeper at the successive periods of the case. The symptoms of three distinct illnesses of the patient were identical in their characters; and they were those of no other known disease. Lastly, after death, no diseased change, capable of accounting for the fatal result, or for the symptoms during life, was found, except the disease, which had destroyed the proper texture of the supra-renal bodies. On the other hand, the case shews that these bodies are not so immediately essential to life, as was inferred from the results of the earlier experiments of removing them made on animals. Their proper structure must here have been long destroyed; yet, five weeks previous to death, the patient was at his ordinary work, and, as he believed, quite well; and, his more severe symptoms did not begin until seventeen days before his death. From these facts, and, from the whole course of the case, it is probable that the more serious ill effects of disease of the supra-renal capsules are due, not to the arrest of their special function, but to the secondary action of the disease seated in them, from time to time, upon other organs of the body through their very numerous nervous connections. This secondary action of their disease seems, in the present case,

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to have been manifested on three occasions, and on each succeeding one with increasing severity. The discoloration of the skin appears, likewise, to have become deeper on each of these occasions; but it never disappeared after its first production, and may be a direct result of the destruction of the proper substance of the supra-renal bodies. Amongst the appearances found after death, we may, with great probability, refer the intense congestion of the liver, and the congestion of the kidneys which gave rise to the albuminuria during the two last days of life to the secondary influence of the supra-renal capsule disease.

Dr. BALY, 18*th of November*, 1856.

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2. *Disease of the Supra-renal Capsules, without Destruction of their proper texture.—Bronze Discoloration of the Skin absent.*

The diseased capsules had been taken from the body of a patient who had died of diseased vertebral column in one of the surgical wards of St. Bartholomew's Hospital, and whose skin presented no trace of bronze discoloration.

The disease consisted of nodules of firm substance, grey and semi-transparent externally, and yellow and opaque internally; the grey portion greatly predominating. The microscopic elements were the same as in the case described at page 329, and the disease was evidently the same, but in an earlier stage. A great part of the proper structure of the supra-renal capsules remained apparently unaltered.

Dr. BALY, 18*th of November*, 1856.

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3. *Extensive Occupation of both Supra-renal Capsules by Scrofulous Deposit.—Absence of any Bronzing of the Skin.—Death by Pulmonary Phthisis.*

General *post-mortem* appearances.—Both capsules were greatly thickened, and in each case but a very small amount of natural tissue existed, the remaining parts of the capsule being the seat of a firm yellowish-white deposit, which quite obscured the proper texture of the organ, and had every external appearance of scrofulous deposit in what has been termed the "crude form."

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One supra-renal capsule weighed eight scruples; the other, seven scruples. The right kidney was natural; but the left one, as also the left ureter and the inner surface of the bladder, specially at its base, were the seats of much softened broken down, scrofulous material. The urethra was very vascular and somewhat dilated.

The liver was large, yellow in colour, and very fatty; the spleen was also large and very pulpy. The capsules of both these viscera were thickened and adherent to the diaphragm by old-standing adhesions. The intestines were natural, but the mesenteric glands were somewhat enlarged. The lungs contained large quantities of scrofulous deposit, and vomicæ at their upper parts, and slight pleural adhesions existed on both sides. The heart was small; the left ventricle being contracted, whilst the right one contained much coagulum. The *colour* of the skin was observed to be quite *natural*.

Microscopical Appearances.—Those parts of the supra-renal capsules which were not the seat of foreign deposit, presented none of the natural large and oval bodies which that organ naturally contains, but instead, numbers of round and oval bodies, like white corpuscles of the blood, along with some curled and nucleated fibres. The deposit shewed large numbers of ill-defined non-nucleated cell structures interspersed amidst quantities of granular and fatty matter.

History.—The specimens were removed from the body of a girl, æt. 14, who was brought into St. George's Hospital, having suffered for three months with partial incontinence of urine, and scalding on passing it, which she did every quarter of an hour. Sudden stoppage of the water, which was very alkaline, containing blood and pus, and other symptoms led to the suspicion of stone, but the sound did not prove its presence. After a time symptoms of phthisis set in, and she quickly sank and died.

Remarks.—In the above case there was no alteration of the colour of the skin, such as has been lately attributed to disease or destruction of the supra-renal capsules, even although almost all the gland structure was invaded by the deposit; that

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which was not so occupied being also in anything but a natural state. Neither were there any of the grave symptoms, such as have appeared to some to follow destruction of these bodies: among which, according to Brown Sequard, convulsions and coma are to be classed. Should any slighter symptoms have arisen owing to the affection of the supra-renal capsules, they were of course merged in those arising from the phthisical state of the lung.

Dr. JOHN OGLE, 18*th of November*, 1856.

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4. *Extensive Deposit of Scrofulous Matter in one of the Supra-renal Capsules.—Death by Pulmonary Phthisis.—Absence of any mention of Bronzing of the Integument.*

The case was described in connection with the preceding one, although the specimen, owing to misplacement in the St. George's Hospital Museum, was not produced. The specimen consisted of a supra-renal capsule removed from above the right kidney. It was very large, and very adherent to the kidney below it, and to the liver above it. Its investing membrane was much thickened and hardened, and the whole of the gland was the seat of scrofulous deposit. This deposit, at the posterior part of the capsule, was very softened and broken down into a pus-like fluid. The left supra-renal capsule had no unnatural appearances. The kidneys were congested, but nothing more. The spleen and intestines were natural, as also the mesenteric and other lymphatic glands. The liver was also healthy, excepting that part of its surface to which the diseased supra-renal capsule was adherent. Here it contained a small mass of scrofulous material within its substance. The heart was healthy, but the lungs were emphysematous, and the seat of scrofulous deposit.

History.—The patient, æt. 36, from whom the preparation was removed, was admitted into St.George's Hospital, in 1853. He was emaciated and depressed, with marked indications of phthisis. He died ten days after admission; hectic, loss of appetite, and abscesses about the arms, preceding death. It is mentioned in the description of his case, that the skin of the face

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was dusky, evidently from venous congestion, but there is no mention of any noticeable stain or bronzings of the integument; and hence it may be inferred, that nothing of the kind existed.

Remarks.—As in the case immediately preceding the present, all the symptoms were simply those arising so commonly in one dying of pulmonary phthisis. Nothing appeared which could be precisely traced to any disorganization of the supra-renal capsule; but, of course, it may be rejoined, that only one of the capsules was diseased. This latter fact renders the case more or less imperfect, as regards our power of tracing the influence of those bodies, when diseased, upon the general system. Yet, in our present imperfect acquaintance with their pathology, it would appear incumbent upon all to adduce every case which would cast even the slightest light upon the subject in question. In allusion to kindred cases brought before the Society previously, Dr. Ogle referred to another case brought forward by himself, and related at p. 177, of Vol. vii. of the "Transactions," in which, although the left supra-renal capsule was entirely disorganized by the presence of a quantity of fatty material, yet no bronzing of the skin had occurred, and no special symptoms had arisen in connexion therewith.

Dr. John Ogle, 18*th of November*, 1856.

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5. *Cancer of Supra-renal Capsules and of other Organs. No Discoloration of the Skin.*

S. B., æt. 18, a tentmaker, was admitted into St. Thomas's Hospital, under the care of Dr. Peacock, on the 31st of December, 1855. She stated that about three months before she had been suddenly seized with severe pain in the right hypochondrium, for which she had medical advice; and she was also said to have injured herself by a fall some time previously. When admitted, she had slight febrile symptoms, and complained of pains in the limbs, and especially in the left knee and thigh, and the knee was swollen and tender. Some febrifuge medicine was first prescribed and subsequently the iodide of

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potassium and colchicum in small doses were given, and morphia to procure rest at night. Under this treatment the general rheumatic symptoms subsided, but the affection of the left knee remained, and she became weaker, had a morbidly red tongue, a very torpid state of the bowels, rapid pulse, and great pain and restlessness at night. Wine and a generous diet were now given, with quinine and iron.

On the 12th of February, the left foot and leg had become œdematous, and she suffered great pain in the knee, and the joint was red and swollen. The swelling increased so that it soon extended above the knee; a small gland was felt in the groin, but there was no tumour to be detected in the abdomen, nor any enlargement in the course of the femoral vessels. She was now becoming rapidly more emaciated and prostrated. The urine was not albuminous; the respiration beneath the clavicles was attended with slight sibilus, but no decided evidence of disease could be detected. It was, however, inferred that there was some deep-seated tumour in the abdomen, and probably commencing disease in the lungs. At the end of the month the anasarca had increased and involved the whole thigh, and in some degree the abdominal parietes so that the enlarged gland could no longer be felt. The abdominal cavity was somewhat distended, but tympanitic; the liver was rather enlarged. The spine at the last dorsal or first lumbar vertebra was unusually prominent, and there was some fulness of the left lumbar region. The superficial veins of the abdomen were much enlarged.

In the middle of March she was seized with acute bronchitic symptoms, and she died, exhausted by continued suffering, on the 1st of April. In the last period of her life the presence of a large tumour in the left side of the abdomen was very obvious. Throughout her illness, there was never any discoloration of the skin, her complexion being, indeed, unusually pale and clear. This fact specially attracted attention; and it was concluded, in consequence, that the disease under which she laboured, would more probably prove to be of a strumous, than of a malignant nature.

Post-mortem examination. — Of ordinary stature, somewhat

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emaciated and exceedingly pale. There was not the slightest trace of bronzing on any part of the body. The left lower extremity was distended, almost to bursting, with effusion of serum.

Chest.—Pericardium and heart healthy. The lungs were free from adhesions. The right lung was of ordinary size; its surface presented numerous projections, and in some places, almost pedunculated lumps, from the size of a horse-bean downwards: these were scattered with tolerable uniformity, but were, perhaps, most numerous about the base. They were soft, pulpy, and white, and appeared to have originated in the sub-serous tissue, or in the superficial portion of the lung. On section, similar deposits were found to be scattered pretty thickly throughout the substance of the organ. There were no cavities at any part, nor any tendency towards breaking down. The lung-tissue between the deposits was crepitant and healthy. The bronchial tubes were tolerably healthy, but contained more secretion than usual. The left lung was in the same condition as the right: but the size and number of the deposits, both on the surface and in the interior of the organ, were less than in the opposite one. The glands occupying the bifurcation of the trachea were enlarged to about the size of a hen's egg, had become more or less blended with one another, and were infiltrated with a soft, creamy-juice-yielding material. At the base of the right pleural cavity, close to the posterior mediastinum, was a nodulated growth, projecting about half an inch, and having an area equal to a five-shilling piece. Several smaller patches of the same kind were scattered about in the neighbourhood. They had the same characters as the growths connected with the lungs and that in the bronchial glands.

Abdomen.—The peritoneum was, for the most part, healthy; but the pelvic portion, and especially that part of it lying between the uterus and rectum, was covered by nodulated vegetations. These formed patches of various sizes, which ran more or less into one an other, and which projected, on the average, about half an inch above the general surface. The liver was of ordinary size; its substance was, for the most part, healthy, but it was studded, though not very thickly, with soft, white, cancerous masses, from the size of a Spanish-nut downwards.

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Many of them reached the surface, where they formed roundish and somewhat projecting patches, which had, in scarcely any instance, the cupped appearance common in hepatic cancer. Spleen, pancreas, stomach, and intestines, healthy. The lumbar glands formed a soft cancerous tumour, about as large as a walnut, in which the aorta and vena cava were embedded, without, however, being materially compressed by it. A chain of diseased glands extended thence along the left iliac vessels into the left groin, in which situation was another mass of cancerous glands as large as a hen's egg. The common and external iliac veins were filled by an adherent fibrinous coagulum. The kidneys were much enlarged and irregular in shape. On removing their capsules these alterations were found to be due to cancerous growths, which were irregularly distributed, and which projected unequally. On section, the masses were found to be, for the most part, globular, varying in size from a pigeon's egg downwards, generally clustered, and more or less blended with one another. They were soft and white, with a very definite margin. Many of them gave origin to nodulated growths, which projected into the cavities of the organs. In the situation of each supra-renal capsule was a mass of soft cancerous material, which had the lobulated character of a tumour produced by malignant disease of lymphatic glands, and, indeed, it was continuous with the lumbar tumour. A very careful examination was made, but no appearance whatever of healthy supra-renal glands was detected, so that there was no doubt that the whole, or a part, of each of the masses was due to cancerous disease of these organs. In each case a portion, about as large as a chestnut, could be pointed out as being indubitably a part, at least, of the bodies in question. These portions were rather firmer and more fibrous than the surrounding cancerous growths; though to the naked eye they presented some of the characters of healthy supra-renal capsules, yet under the microscope, they displayed little else than the elements of cancer, such as they existed in the other organs. The left knee-joint was much swelled, and, on examination, it was found that the joint itself was tolerably healthy, but that the shaft of the femur, immediately above the joint, for about two inches of its length, was surrounded by a pulpy

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cancerous growth which appeared to have originated in the periosteum.

The cells which characterised the above growths were rather peculiar, being large, irregular in shape, and presenting frequently one or more tail-like processes. The nuclei within them were peculiar also: they were usually large, sometimes round or ovoid, but frequently irregular. Their size varied considerably, and frequently it appeared as though the nucleus were becoming enlarged into a cell, and as though another nucleus or other nuclei were making their appearance within it.

Dr. Peacock, and
Dr. Bristowe, *2nd of December*, 1856.

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6. *Cancer of the Supra-renal Capsules, associated with Cancer in other organs.—No discoloration of the Skin.*

W. M., æt. 55, was admitted into St. Thomas's Hospital, under the care of Dr. Peacock, on the 3rd of June, 1855. He stated that he had worked for forty-six years as a copper-smith, and had never suffered from any illness, except an attack of cholera, till the commencement of his present indisposition. He first became unwell four months before his admission, and had gradually declined in strength and flesh, but he was able to follow his employment till within one month. When admitted he complained of pains across the shoulders, in the small of the back, and in the limbs, with general want of power, but without any decided paralytic symptoms. He was much emaciated and his expression of countenance care-worn. The tongue was covered with a slight white fur; the gums were retracted from the necks of the teeth, and the exposed surfaces were covered with a dark offensive coating. There was a line, about two lines wide, of a deep purple colour which extended along the margins of the gums and which was most distinct in the upper jaw. He had lost many teeth, and stated that they loosened and fell out without suffering. He had a slight cough and expectorated a little dark coloured mucus; there was some rhonchus in the posterior parts of the chest, but the resonance on percussion was not impaired, except slightly at the upper part of the right side. The skin was of natural colour.

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There being no evidence of disease sufficiently marked to explain the emaciation and anæmia, and a purple line existing round the gums, it was thought probable that the case was one of copper impregnation; and the iodide of potassium and liquor potassæ were accordingly given in conjunction with tonics, the decoction of bark, wine, and nutritious food. Under this treatment, however, he did not improve, but gradually became weaker and more emaciated, and the cough and expectoration increased. He was then ordered the quinine and iron, and the cod-liver oil, and as the stomach became irritable, and his food was occasionally ejected, and the bowels became relaxed, brandy and astringents were given, and morphia at night. He still continued, however, to decline, the chest symptoms continued, the phthisical signs became more marked, and he died exhausted on the 30th of August. The urine was several times tested and found healthy, and after death the gums were examined by Dr. Dundas Thomson, and tested for copper, lead, and mercury, without presenting any trace of any of these metals.

Post-mortem examination.—Rather tall and extremely emaciated. There was no trace of anything like bronzing on any part of the surface of the body.

Chest.—Pericardium healthy. The heart was for the most part healthy; in its right margin, however, near the right auricular appendage, was discovered a small projecting lump about as large as a pea; and in the substance of the posterior wall of the right auricle another lump as large as a horse-bean. Both of these were white, soft, and yielded cream-like juice on pressure. The pleuræ presented a few old adhesions, but were otherwise healthy. The lungs were for the most part crepitant; each of them, however, contained from four to six masses, (from the size of a pigeon's egg to that of a marble) of a soft, white, creamy-juice-yielding material. The masses were distinctly circumscribed, and had all the characters of encephaloid cancer. Besides these, there were in each lung several masses formed by the solidification of two or three contiguous lobules, in which the colour was as nearly as possible that of the surrounding lung tissue, and which appeared to be an early stage of the same form of disease. Two or three of the ribs on each side (from the seventh to the

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ninth inclusive) near their angles, formed soft, projecting, nodulated masses, which encroached a little on the pleural cavity. On removing the ribs, it was found that the diseased appearances, were due to cancerous infiltration of the ribs themselves in the situations above indicated. The diseased portions of the ribs, which were from one to two or three inches long, were three or four times as thick as natural, nodulated on the surface, and formed wholly of soft encephaloid cancer, studded with small fragments and spicula of bone.

Abdomen.—Peritoneum healthy. Liver, spleen, pancreas, stomach, and intestines, all healthy. The supra-renal capsules were enlarged and plump, their greatest thickness being about three-fourths of an inch. They appeared to be wholly destroyed, their original substance being replaced by a soft, white, encephaloid deposit. Here and there, however, on the surface, and along the edges, were blackened patches, the discoloration in which had been produced by decomposition, and which possibly may have been the remains of original structure. But, it is not at all clear, that they were so, and even if they were, they formed a very small portion of the whole. The right kidney was small, and weighed about three ounces. It had the appearance of being somewhat atrophied, but did not seem to be affected by any special disease. The left kidney was much enlarged, and its upper part formed a globular tumour, about as large as a good sized orange. This tumour had originated in the upper third of the organ; its circumferential portion consisted of white encephaloid matter, here and there studded with congested patches and extravasations of blood; its central part, and apparently one-half of its entire bulk, was formed partly of a buff-coloured and somewhat friable fibrinous material, and partly of a delicate net-work of lymph, the intestines of which were occupied by straw-coloured serum; and altogether, had the characters presented by recently effused œdematous lymph. The lower part of the kidney was in the same state as the right one.

Under the microscope all the tumours were found to present the ordinary characters of encephaloid cancer, consisting almost entirely of nuclei, and a delicate fibroid stroma. The diseased supra-renal capsules displayed the same microscopic structure as

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the cancerous masses in other organs, and none of the normal tissue was detected.

Dr. Peacock, and
Dr. Bristowe, *2nd of December*, 1856.

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7. *Report on Dr. Gibbs' Specimen of Cancer of the Supra-renal Capsule.**

The mass submitted to examination was about the size of an egg, and consisted throughout its substance of a very vascular medullary cancer. Cells, with from one to three large distinct nuclei were abundant, and there were also vast numbers of free nuclei possessing large dark nucleoli. No portion of healthy supra-renal capsule structure could be found; indeed, from its present state, it would have been quite impossible to say from what organ the mass had been developed. The tuberous mass in the liver was of like character with that in the supra-renal capsule.

Dr. Wilks, and
Mr. Hutchinson, *4th of December*, 1856.

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8. *Diseased Supra-renal Capsules, in the Cat.*

These specimens were removed by operation from a cat. A considerable portion of the glandular, as well as of the cortical, structure of the organs had become replaced by a calcareous deposit, which chiefly consisted of carbonate of lime. The remaining portions of the glands contained so much fibrous tissue, that the normal structure might be said to have entirely disappeared; yet notwithstanding that the functions of the organs must have been nearly or wholly destroyed, there was no appearance of the animal's health having suffered any derangement; an important fact, when it is remembered that Dr. Addison supposes that supra-renal capsular disease is accompanied by extreme emaciation and debility. As patients rarely die of supra-renal capsular disease alone, it may yet be a question whether or not we are right in attributing the emaciation and weakness to the disease of these glands, for in the above example,

* *Vide* page 255.

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where they were the only organs diseased, the animal's health was not in any way affected.*

Dr. HARLEY, *17th of February*, 1857.

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9. *Bronzing of the Skin.—Supra-renal Capsules Healthy.*

The specimens consisted of two supra-renal capsules, and several portions of discoloured integument. Of the capsules, more need not be said, than that they were perfectly healthy, and of good size and plumpness. The portions of skin shewed a most marked condition of bronzing being nearly as dark as that described at page 328, (Dr. Baly's case of Bronzed Skin, with Diseased Capsules). The darkest portion had been taken from the abdomen, midway between the umbilicus and pubes. Under the microscope it shewed a large deposit of pigment in its rete mucosum. As the case affords, I believe, the first proved exception to the connection of this discoloration of the skin, with disorganization of the supra-renal bodies, I shall state its facts in some detail. They have been furnished to me by my friend, Mr. Joseph Allen, of the Liverpool Royal Infirmary, by whom the *autopsy* was conducted.

C. V., æt. 25, was admitted into the Hospital on the 18th of February, 1857, suffering from dyspnœa and pain in the left side. He was a well-built and muscular man. Countenance bloated, and dusky, expression anxious and distressed. His urgent symptoms were all referrible to the lungs, but, on uncovering the body, a remarkable discoloration of the integument was observed. The skin of the chest was of a tawny, bronze colour, with a darker tinge around the nipples. The colour was of the deepest hue across the loins, lower part of the abdomen, and inner parts of the thighs. The entire surface of the body, however, presented more or less of this bronzed appearance. There were abrupt margins to the darker parts, which gradually faded off into those not so much discoloured. The scrotum was of a blackish-bronze tint, and the

* The above case, although it would otherwise have been introduced amongst the Specimens from the Lower Animals, has been introduced here as bearing upon the interesting question of the effects of Disease of the Supra-renal Capsules upon the animal economy.—ED.

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penis not much lighter. The upper extremities, and face, and the upper half of the body generally were much less discoloured than the lower; indeed, the bronzing was not noticed at all, until the chest was exposed. The conjunctivæ were pale and sallow; the lips dark and livid, from congestion. There were no dark patches in the axillæ; indeed, there was no appearance of patches in any part, excepting the areolæ of the nipples. No part of the skin was of healthy whiteness.

No history could be obtained from the man as to where the bronzing had commenced; but he had noticed its existence, and believed that he had lately been getting gradually darker. He was a sailor, and had been out to the Crimea, from which he had only just returned. Whilst there, nearly two years ago, he had an attack of yellow fever, for which he was salivated. Since that, he considered that he had never been well; his skin, at the time, was much tinged, but he felt certain, that lately, it had got much darker. Before going to the Crimea, his skin was white, like other people's. His parents were both of them English, and free from colour. His present illness and chest symptoms had existed for about ten days, and he was rapidly getting worse.

The urgent symptoms being those of pneumonia, a suitable treatment was adopted; but he, notwithstanding, got worse, and death took place on the fourth day after admission.

At the *post-mortem* examination which was made thirty-four hours after death, it was noticed that the skin did not appear so dark as it had done during life; the rigidity had disappeared from the upper extremities; the muscles were plump and well developed. The following is a statement of the condition of the various viscera:

Pleuræ.—Right side.—Lung generally adherent, adhesions firm, a band from the whole of upper portion of fourth rib, to the spine, confining the lung; the space thus formed between this and the diaphragm full of serum.

Left side.—A few adhesions posteriorly, and at apex.

Lungs.—Right.—Lung almost entirely solidified throughout; portions, more especially of the inferior lobe passing into third stage of pneumonia; the whole lung easily breaks down giving more

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the appearance of the spleen. At the apex, deposit of a white cartilaginous appearance, puckered; lung around softened.

Left.—The greater part of the lung in the second stage of pneumonia, except at the extreme margins, and anteriorly lower portion of upper lobe, which was emphysematous, and in part collapsed; some few lobules pneumonic.

Bronchial Glands.— Enlarged, not apparently diseased.

Pericardium.—Universally adherent; on left side adhesions could be broken down, leaving a rough, blood-stained surface.

Heart.—All the cavities contained coagulated blood, (right cavities somewhat dilated;) no valvular disease.

Liver.—Marks of old inflammation on diaphragmatic surface; tissue healthy.

Spleen.—Large, firm, healthy.

Kidneys.—Large, healthy, congested.

Mesenteric Glands.—Enlarged, no deposit.

Intestines.—Not examined.

Brain.—Firm; vessels, congested; no excess of fluid in ventricles; the testes were large and flattened out somewhat; pituitary body, firmly attached to the dura mater; nothing else worthy of note.

The pituitary body and supra-renal capsules were sent to me for inspection. Respecting the latter, it has already been said that they are in every respect normal. My friend, Dr. Gull, was good enough to examine the former for me, the attention which he has given to that organ in its diseased and healthy states making me particularly desirous to have his opinion as to its state. The following is his report respecting it:—*

"I have examined the pituitary body which you sent, it is not in a normal state. The posterior lobe is very small, and partly

* It may be of interest to state that the pituitary body was deemed of importance in this case, on account of an opinion expressed in conversation by Dr. Gull to the writer, that it was closely associated in function with the supra-renal bodies. Dr. Gull, who has carefully examined their structure, believes that in anatomical characters there are some marked resemblances between the two organs. It would be premature to speak at all positively on the subject, but it may be worth just stating that in one case of bronzed skin in which the supra-renal capsules were disorganized, the writer found the pituitary body much diseased and containing a large cyst.—J. H.

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degenerated into an amber-coloured, waxy substance. The anterior lobe is also diseased, being smaller, tougher, and much more vascular than usual, and its cellular structure less distinct. I shall be greatly interested in the details of the case."

Remarks. — The preceding case must be admitted to prove conclusively that the pigmentary bronzing of the skin may depend on causes distinct from disease of the supra-renal capsules. Nor would it have been easy during life to have distinguished such an one from examples of the disease described by Dr. Addison. The circumstance that the man had retained a good degree of health and strength, and was able until within a fortnight of his death to follow his occupation, was certainly very different from the usual course of things in supra-renal capsular disease. So also was the fact, that the lower half of the body was the deeper in tint, the face being nearly exempt. There was no reason to believe that the man had ever taken nitrate of silver, nor was the tint at all like the grey, slatey hue caused by that salt. Perhaps the most probable supposition is, that during the yellow fever, a quantity of colouring, perhaps biliary matter had been thrown into the skin, and instead of clearing off on recovery, it had effected a permanent change in the rete mucosum, inducing it to secrete into itself yet darker pigmentary matter. The writer has recently seen three or four cases in which the colour of the skin is such, that were the cachexia marked and progressive, he could not hesitate to diagnose diseased capsules, but in which, from the opposite being the fact, he has formed a contrary opinion. In none of these has death occurred or indeed is at all likely to do. He wishes to direct attention to the very different significance of these cases in respect to Dr. Addison's theory, to those, (did they exist), of totally disorganized capsules without change in colour. It must be admitted as very probable that a darkening of tint of the skin may be due to many different causes, amongst which, disease of the capsules ranks but as a single one. In a large majority of these, however, a careful examination of the history and general features of the case, would enable a confident diagnosis to be arrived at. In regard both to the frequency of its occur-

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rence and the degree of change in colour produced, we may also still assert, that disease of the supra-renal capsules holds a most prominent place in the list of efficient causes.

Mr. HUTCHINSON, *17th of March*, 1857.

IX. TUMOURS, ETC.

1. *Recurrent Fibrous Tumour of the Muscles of the Calf of the Leg.—Amputation of the Limb above the Knee.*

In the sixth volume of the Society's "Transactions,"* Mr. N. Ward has given a minute account of a small fibrous tumour, which I excised in March, 1855, from the gastrocnemius muscle of a girl, aged 9, a patient in the London Hospital. The limits of the tumour seemed, on examination, to be defined, but at the operation I was disappointed in finding that the growth extended irregularly into the substance of the muscle; and as the whole disease could not be excised without removing the entire belly of the gastrocnemius, the dense central portion and the diseased muscular substance immediately around, were alone taken away. The minute examination of the tumour, which has been fully described by Mr. N. Ward, indicated its fibroid character. After the healing of the wound, which was somewhat protracted, I divided the tendo-Achillis in order to correct the extreme talipes equinus consequent on the growth. The girl left the Hospital, able to walk, about three months after the operation.

This girl was re-admitted into the Hospital, on September 16th, 1856, on account of a return of the tumour in the calf of the leg, and of the talipes equinus. The mother first noticed the recurrence three months after she left the Hospital. There was an ill-defined mass, containing several hard nodules, some of them adherent to the cicatrix and adjoining skin. It was impossible to determine whether the disease was limited to the belly of the gastrocnemius or extended to the deeper muscles. In the hope that it might be confined to the gastrocnemius, I determined on an operation with a view to its excision. But

* Page 345.

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upon proceeding to detach this muscle, Oct. 9th, 1856, I found the soleus extensively affected, and the disease so deeply seated, that it could not be removed without amputation of the limb. With the concurrence of my colleagues, I desisted from going on with the excision, and at once performed amputation above the knee.

On examination, the tumour was found to extend from the lower part of the popliteal space to the middle of the leg, its shape being pyriform, with the base above and the apex below. The under part of the tumour was embedded in the deep flexors of the leg, and was connected with the inter-osseous membrane, and the periosteum of both tibia and fibula. The tumour consisted of irregular spherical masses matted together. The cut surfaces were pellucid, firm, and somewhat granular. The muscles of the leg, in the immediate neighbourhood of the tumour, were pale, wasted, and traversed by thick fibrous septa. The knee-joint and muscles of the thigh were quite free from disease. The morbid growth was carefully examined by Dr. A. Clark, and its minute characters were found to be similar to those observed in the tumour first removed by me, and described by Mr. N. Ward. MR. CURLING, *21st of October*, 1856.

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2. *Large Myeloid Tumour in the Head of the Humerus.—Re-section.—Recovery.—Death from Cancer.*

INDEX TO CASE.—*Supposed fracture of the neck of the humerus in a young woman.—Permanent loss of motion, and gradual enlargement above the part.—Amputation at the shoulder-joint advised fourteen months after the accident, on account of a large tumour which had formed;—refused by the patient.—Arrest of growth in the tumour for four years.—Subsequent rapid growth and enlargement of glands.—Re-section of the upper third of the tumour (myeloid and fibro-plastic) and of the diseased glands (fibro-plastic).—Recovery, with an useful arm, but rapid re-production of the disease in four different parts.—Death five months after the re-section, from an enormous mass of sloughing and bleeding cancer. Post-mortem.—Cancerous growths connected with the bone, in the axilla, in the cervical glands, and in the lung.*

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J. R., æt. 33, single, a sempstress, was admitted under my care into the Metropolitan Free Hospital, on the 23rd of April, 1856, on account of a very large tumour affecting the head and upper part of the shaft of the right humerus. The tumour, which was fully the size of an infant's head, concealed all the natural prominences of the shoulder above, and extended downwards about one third the length of the arm. The skin over the front aspect was loose; but posteriorly it adhered to the growth.

The deltoid muscle, in all parts, seemed to be inseparably united to the growth. There was no movement whatever at the shoulder-joint. To the touch, the tumour, in front and beneath, was as hard as if encased in bone; but behind and above, it resisted less firmly, and had a semi-elastic yielding in parts, as if from cysts. In the axilla were large nodular out-growths of bony hardness, and between two of these, in a deep furrow, the vessels and nerves were lodged. The shaft of the humerus below the tumour appeared of natural size, and the commencement of its expansion to form the tumour was sudden and easily felt. Below the axilla, and about on a level with the nipple, was a cluster of enlarged and very firm glands, the individuals of which were from the size of walnuts to that of eggs; the whole being loosely connected, and forming a mass considerably larger than a fist. None of these glands adhered either to the skin or to the deep parts. The woman was pale but moderately stout, and not of any very marked degree of cachexia. The pulse ranged from seventy to eighty-four, her appetite and digestion were good, and, until the last week or two, she had continued to earn her livelihood by her needle.

History.—Six years ago, in a severe fall, she dislocated her shoulder, and also broke the bone near the joint; at least such she avers was the statement made to her at the London Hospital, where she was admitted, and had it reduced. She remained in the Hospital a week or two, and had splints applied. The shoulder, ever after, continued stiff; but she had no noticeable enlargement until about fourteen months afterwards. Four years ago, that is, ten months after the enlargement was noticed, she was again admitted into the London Hospital, under the care of

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Mr. Luke. She believes that the tumour was then, at least, two thirds its present size; it had grown rapidly and been very painful. Several consultations took place; she was assured that the disease was "cancer of the bone," and amputation at the shoulder-joint was strongly urged upon her. This she refused to submit to, and was accordingly discharged. For a few months subsequent to her dismissal, the increase in size continued; but, subsequently, it quite stopped, and the pain ceased. Although her shoulder was immoveably fixed, yet her arm was very useful, and, during the four following years, she earned her livelihood by her needle, and enjoyed good health. In August, 1855, she, for the first time noticed the enlarged glands under the armpit, which have since rapidly increased. The tumour itself also, at the same time, began again to increase in size, and became the seat of severe pain.

The association of gland-disease with so large a tumour in the head of a bone seemed sufficiently indicative of malignancy of nature to make it very desirable that the whole arm should, as soon as possible, be removed. The circumstances of the case were, accordingly, represented to the patient, and amputation strongly advised; it being proposed to perform the operation either at the shoulder-joint or through the scapula, as might be found needful. To this, however, the woman resolutely refused to consent, believing that, as the tumour had been quiescent for so long a period, it might again cease to be painful, and allow her the use of the arm. Under these circumstances, and with the concurrence of my colleagues, I determined to perform the re-section of the growth, and of that part of the bone involved. It should be here stated that during the month the woman had been under observation as an out-patient, the glandular tumour had greatly increased in size, and that her health had manifestly declined. The nights had been rendered almost sleepless by pain.

Operation, (14th of May.)—Two long incisions having been made, meeting at an apex a little below the insertion of the deltoid, the flap of skin, which was triangular, and had a broad base over the shoulder, was dissected up. This flap consisted merely

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of skin, for the deltoid muscle was found inseparably involved in the growth, excepting at its borders. At the posterior part the skin also adhered to the growth, and a second curved incision, including a crescentic portion of it, was accordingly made joining into the outer side of the triangle above and at its apex. This done, the upper surface of the growth was well exposed, and, the next step, consisted in sawing through the shaft of the humerus at the commencement of its middle third, which was accomplished by means of a Hey's saw, the soft parts being held away by retractors. The lateral connections of the mass were next freed, a dissection requiring much care, as the vessels and nerves were embedded in a deep furrow, formed by projecting, nodosities of the growth. Before accomplishing the disarticulation, it was found necessary to saw away the acromion and the coracoid process, and, even then, it was not done without much difficulty, on account of the tumour, in its growth upwards, having embraced the articular head of the scapula, which was firmly lodged in a cup at least an inch in depth. Only one vessel required ligature, (the posterior circumflex,) and it was of large size, and had been divided very near to the main trunk. The bleeding had, throughout, been but slight, and the patient, when returned to bed, was in very good condition. The large mass of glands, from the infra axillary space, had been removed by a second incision, which did not join that made for the resection of the bone. A length, amounting to about one-third of that of the shaft of the humerus having been removed, the arm was greatly shortened. There was no difficulty, however, in lifting the elbow up, so that the upper part of the humerus, where sawn across, came nearly in contact with the glenoid cavity, and, in this position, it was retained by a bandage.

After-progress of the Patient.— The shock of the operation was not unduly felt. Opiates and tonics were freely employed, and, although for three weeks, the suppuration was very profuse indeed, yet the healing rapidly progressed. At the end of this time, however, an enlarged gland was discovered just behind the edge of the sterno-mastoid in the neck, which, from its mobility, painlessness, and firmness was evidently in a state of specific disease, and not of mere enlargement from irritation. At the end of about

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six weeks the woman was able to sit up, her arm being supported by a sling. An indurated condition of the cellular tissue of the supra-spinous fossa had subsided under repeated applications of iodine. About ten weeks after the operation the main wound was healed; that by which the glands had been removed, still, however, remaining open at one spot. The woman was now able to use her forearm and hand, though she could not dispense with a light sling for the support of the elbow. The shortening of the upper arm, and the perfect state of the forearm, presented a curious want of symmetry, when contrasted with the opposite; but there appeared every reason to expect that the limb would very shortly be an exceedingly useful one. About this time, however, a mass of thickening became perceptible, connected with the upper extremity of the humerus, and, almost simultaneously, a mass of fungous growth sprouted up from the unhealed sinus left by the infra axillary wound, about the nature of which there could be no doubt. I had hitherto intended to remove the enlarged cervical gland above spoken of, as soon as she would allow its being done; but, as it was now evident, that the disease was returning in two other distinct places, the idea was relinquished. After this, the disease grew with great rapidity in each of its three different sites. The cicatrix of the incisions partially gave way, and a large fungus projected. The patient became pallid, and had the aspect of malignant disease, though she did not emaciate remarkably. The largest growth was from the infra axillary region, and, from this, repeated hæmorrhages took place. After one of these, the woman sank and died, about five months having expired since the operation.

Examination of the original and the recurred growths.—The head of the bone after removal presented a good example of the mixed fibro-plastic and the myeloid tumour. It was about the size of an infant's head, and was in most parts encapsuled in a thin layer of expanded bone. In some parts, however, only the periosteum existed, and in others even that had given way, and adjacent muscle was involved. This was the case over the upper and outer part where the whole thickness of the deltoid adhered to the growth, and had undergone transformation into a pale grey

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fibroid structure. On section, the growth shewed a surface varying in different parts from a pale grey to yellow, and even brown. It was firm in texture and exuded very little juice, but in parts was softer than others. Deposits of soft spongy bone existed in several parts, but all traces of the contour of the shaft were wholly destroyed. Under the microscope many of the large poly-nucleated cells, characteristic of the myeloid growths were seen, but in much larger number were the mono-nucleated cells of the fibro-plastic class; excepting numerous free nuclei, there were no elements at all resembling those of cancer. The presence of the myeloid and fibro-plastic bodies being a fact of importance, I am glad to be able to substantiate it by reference to the authority of my friend Dr. Bristowe, who kindly examined the tumour within a day or two of its removal. He writes, "some of the tissue is as beautiful myeloid tissue as one could wish to see; its myeloid cells are models. In other parts the tissues might very properly be termed fibro-plastic." I may remark that the tumour bore a more close similarity to one shewn by Mr. Shaw at a former meeting of the Pathological Society, and on which Mr. Henry Gray and myself were deputed to report, than any other that I ever examined. Mr. Shaw has recently informed me, that in his case, no return of the disease has as yet taken place. The glands removed from the infra-axillary space were about the size of large walnuts, and made up altogether a mass the size of a fist. They all presented similar features, being firm and tough, but not hard, and shewing a homogeneous, opaque, grey-white surface on section; no juice exuded. I could find on careful search only fibroid and fibro-plastic elements; no myeloid cells were discoverable. The glands, quite different from what is usual in cancer, were quite loose from each other, and were also very loosely attached to the adjacent cellular tissue, their capsules being very thin. Thus, then, as far as the examination of the growths went, there appeared good reason to hope that the disease might not return, since, although the glands had become affected, yet they did not shew any of the elements of cancer. The long duration of the original disease in the bone also favoured this expectation. That it was destined to be disappointed we have already seen.

Post-mortem.—The recurred growths differed remarkably from

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the original ones. In the axilla was a mass the size of an adult's head, ulcerated and sloughy, the section of which shewed all the characters of soft cancer. It exuded most plentifully a white cream-like juice, which abounded in free nuclei, and contained some large cells, having from one to three nuclei. Springing from the periosteum of the shaft of the humerus, at the point of section, was a large growth of similar character to those described, only not quite so soft. In the neck were numerous enlarged glands, and some of these resembled those removed at the operation more nearly than the recurred growths, and had probably existed in the diseased state almost from the date of the operation, if not before. In the right lung were several deposits of infiltrated soft cancer resembling the growth in the axilla. I may here add that the growths were examined by Mr. Paget, who expressed an unhesitating opinion as to their cancerous nature. The shaft of the bone itself was still healthy, and was united to the lower edge of the glenoid cavity by a thick ligamentous band, so strong that the bones could not be separated by any moderate force. The union permitted of free motion in all directions.

Pathological lesson of the case.—The above case tends strongly to support the views of those who regard cancer as less of a specific disease than has usually been taught, and who believe that there are links of connexion between it and various other growths. It shews that a tumour may be of mixed structure; that one, not in itself actually malignant, may give rise to glandular enlargement of specific, but still not of cancerous nature; and finally that after removal of tumours of the kind adverted to, a very rapid recurrence of true cancer may take place. It would appear indeed, that the patient's constitution had become gradually more and more disposed to the production of cancer. In the first place, she has a broken bone, and from some constitutional defect, a large growth forms at the seat of injury; but this growth is not cancer, and having attained a certain size it remains in *statu quo* for four years, she being meanwhile in good health. Then a period of renewed growth commences, and the new phenomenon of gland enlargement is added. On removal, the tumours are found to consist of mixed myeloid and fibroplastic; the glands, the last to enlarge, consisting solely of

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the latter. Now, it will generally be admitted that the fibro-plastic tumour is more nearly allied to cancer, than the myeloid, and although, usually, returns do not take place after the removal of either, yet the discovery, that the former had recently been superadded to the latter, is *pro tanto* evidence of constitutional deterioration. Besides this, the mere fact of specific glandular enlargement existing, even although the gland disease were most positively not cancer, would induce all of experience to give a guarded prognosis, and would excite anxieties lest the affection, having in this, imitated cancer, should hereafter follow yet further its path; and such was indeed the course pursued in the case before us. The case thus furnishes us with a link of connexion between the myeloid and fibro-plastic, and cancer, and strongly confirms the suspicions which attach to the occurrence of gland disease in connexion with any kind of tumour.

Surgical lesson of the case.—I am not aware of any recorded case in which so large a portion of the humerus was excised as in the above. Many of my friends who saw it were exceedingly sceptical as to whether a useful arm could be obtained after re-section of one third of the length of the bone. In this respect the success was most satisfactory. The preparation is now in St. Bartholomew's Hospital Museum, and shews union of such a kind that there can be no doubt but that had the woman lived longer, she would ultimately have enjoyed almost perfect use of the member. The case most nearly resembling it which I have seen, was one in which about the same length (five inches), of the upper part of the femur had been removed. The subject of it was a soldier, and the bone was removed on account of its having been shattered by a burst shell before Sebastopol. When I examined him the wound was healed, and the thigh, of course, shortened; but he could bear weight on the limb, and it appeared in a fair way to become increasingly useful. There was no reason for thinking, that if in my case amputation had been performed instead of re-section, the final result would have been different from what it was. The first manifestation of subsequent disease was in the cervical glands, which would not, of course, have been removed by an amputation, and the large renewed growth in the axilla was also under similar circumstances. Had

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the disease not been cancer, there is little doubt but that the result of the excision would have been most satisfactory, and of course far preferable to that of an amputation, whilst there is no reason to think that the latter would have afforded any additional security from return of the disease.

Mr. Hutchinson, *May* 1856, *and October* 21*st*, 1856.

Report on Mr. Hutchinson's Tumour.

The specimen consisted essentially of a fibrous growth which had commenced apparently within the head of the humerus. Much of this part of the bone had been destroyed, and other portions so expanded by the growth, that to a great extent, but a mere shell remained, mapping out only, as it were in places, the original outline of the bone. Where the bone had been destroyed the growth had increased to the greatest degree, and become blended with the superjacent muscular tissue. The major part of the growth was of a whitish colour, and of a firm consistence, gradually assuming a pink hue towards the part invested by muscular fibre. Towards the lower part of the specimen, that is, towards the shaft of the humerus, the substance was softer, and in places quite broken down and pultaceous in character, being also of a yellowish-red colour; and this part of the growth was directly continuous with soft material of the same character, situated within the medullary canal of the upper part of the shaft of the bone. In the substance of the firmest and lightest coloured part of the growth one or two cysts existed of about the size of a pea, containing turbid fluid.

Microscopical examination of the central white parts of the growth shewed fibres of variable strength and thickness, having a few granular particles and occasional small nuclear corpsucles mixed with them, such as is not uncommon in fibrous growths; but the same tissue were of a pinkish hue and verging towards the muscle, contained, besides the above named elements a quantity of granular and amorphous material, and this was the case as far outwards as the complete periphery of the growth where the muscular fibres with which the growth was blended appeared to have lost all their distinctive characters, and to be simply reduced to a species of fibroid tissue, having similar amorphous

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material between them. The softer and yellower parts, namely those continuous with that within the medullary cavity shewed fibrous tissue similar to that in the light coloured parts, but broken down and disintegrated, and containing large numbers of oil globules and granular fatty material, with here and there, connective fibre cells. In this latter portion also, and in the material within the medullary cavity there were found a few, but only a very few, oval shaped myeloid bones, and these almost entirely without any projections or elongations, but otherwise well marked.

The lymphatic glands, along with the tumour, only shew microscopical indications of hypertrophy and inflammatory conditions.

Dr. JOHN OGLE, and
Mr. HENRY GRAY, 18*th of November*, 1856.

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3. *Colloid Cancer of the Left Breast.*

Mrs. L., æt. 54, widow, without children, thin and delicate looking, but naturally of good constitution; some four or five years back she first noticed a small swelling in her left breast, which continued slowly to increase in size, and to be accompanied with some degree of pain; the chief inconvenience, however, arising from the weight of the tumour. No cause can be assigned for the appearance of the swelling, nor can any history of cancer affecting any member of her family be obtained. For over three years she allowed the swelling to proceed without seeking any advice. At this time, however, a friend underwent the removal of a cancerous breast, which circumstance, according to the lady's own statement, so preyed upon her mind, that her own tumour appeared to increase much more rapidly in size, and to give rise to continual pain of a dull, heavy character, occasionally severe and lancinating. At the time Mr. Price saw the patient, in consultation with Dr. Ward, a uniform swelling, about the size of a large cricket-ball, of stony hardness, well defined, freely moveable, and apparently not attached to the muscles of the chest, obscured the left breast. The nipple was slightly contracted, and a thin yellowish dis-

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charge, exuded from its surface. The skin over the tumour was healthy, and of natural appearance. The health of the patient has of late become affected by the presence of the tumour. She has long ceased to menstruate. Deep in the axilla, about the size of a small orange, was a round, well defined tumour, which made its appearance about three years after the breast became involved. This swelling was softer in character, and less painful when handled, than the mother tumour, and, although deep, it seemed sufficiently isolated from the great vessels, to admit of removal.

On making a section of the tumour of the breast after removal, the mammary tissue appeared much altered in appearance, and to be infiltrated with a soft, translucent, gelatiniform substance. At various parts the mass assumed a more medullary character, being softer, and more suspicious looking than the chief portion of the tumour. The tumour from the axilla, partook more of the nature of the suspicious looking portions of the mother tumour. The patient made an excellent recovery from the immediate effects of the operation.

Mr. W. Adams for Mr. Price, 21*st of October*, 1856.

Report on this specimen.—Our examination confirms the opinion before expressed, that this tumour was a well-marked example of colloid cancer.

General characters.—The tumour was of a globular form, measuring about three inches in diameter, in some parts more; its external surface was coarsely lobulated, and the lobules were mammillated by the projection of the loculi filled with colloid matter. The tumour occupied the central mammary region, and the nipple corresponded to about the centre of the tumour. A section through the tumour, made close to the nipple, exhibited, beneath the skin, a thick layer of somewhat altered mammary gland tissue, nearly equal in bulk to the entire gland. At its deepest, or posterior portion, this altered mammary gland tissue became opened out, and merged into the true substance of the tumour, the vascularity and blood stained colour of which, rendered the line of demarcation between the tumour and the

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gland tissue more distinct and abrupt than a minuter examination shewed it to be. The section of the colloid portion of the mass was seen to be intersected by thick bands of dense fibrous tissue, corresponding to the coarse lobular division. Within these dense fibrous partitions, the lobules presented the ordinary alveolar appearance of colloid cancer. The alveoli communicated with each other, and contained a greyish, translucent, gelatinous substance in some parts; in other parts this substance had a blood-stained appearance; and some of the loculi contained an opaque, buff-coloured material, evidently an altered condition of the colloid matter, with which in some loculi it was intermixed. The tumour was generally vascular, and many of the alveolar cavities contained extravasated and coagulated blood.

Generally speaking, the loculi, or alveolar cavities were of moderate size; some were about one fourth or three eighths of an inch in diameter, but mostly they were much smaller, and in some parts so small that these portions had almost a solid appearance until closely examined, and being somewhat opaque, these parts might at first be supposed to be of an encephaloid character. The tumour, in its general appearance, differed from some tumours of the same kind, in the greater abundance of fibrous tissue, and in the greater amount of vascularity than frequently seen. Fibrous tissue predominated in some parts where the loculi were very small, and the gelatinous colloid matter predominated in other parts where the loculi were large, and their parietes formed by delicate membraneous septa and fibrous bands.

Microscopic examination.—A section of that portion of the tumour lying immediately beneath the skin, and looking like altered gland tissue, exhibited gland vesicles and ducts embedded in a large amount of areolar tissue.

The gland vesicles were opaque, from an abundance of structural elements which occupied their cavities. These elements were compressed multi-nucleated cells, granule cells, amber-coloured fat cells, free nuclei, oat-shaped and elliptical, acicular and tabular crystals, and amorphous *débris*.

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The walls of the ducts were thickened, brittle, and studded with minute refractive granules. The cavities of the ducts were occupied by an opaque matter, which, when spread out, was found to consist of disintegrating cells, about $\frac{1}{1500}$th of an inch in diameter, particles of oil and fat, and much moleculo-granular matter.

The contents of the vesicles and ducts, the crystals and fat cells excepted, disappeared under the action of liquor potassæ. Acetic acid left visible also a few irregular nuclear-looking particles and granules.

The areolar tissue investing the vesicles and ducts, was thickly studded with nuclei, and, in addition to the white, contained two kinds of elastic fibrous tissue; the one scanty, and of the ordinary description; the second very abundant, and interweaved with the other forms in every direction. It consisted of fine, dark, waved, or curved fibres, varicose at irregular intervals, and branched at such points. Some of the varicose parts seemed to contain vacuoles. The fibres resisted all ordinary reagents.

The colloid matter visible in the deeper part of the tumour could be removed in the form of jointed or club-shaped masses, resembling moulds of the communicating alveoli, in which the matter was contained. Most of these masses consisted of a vitreous, yellow coloured, jelly-like matter, studded with white opaque points, streaks and nodules. These opaque portions, in this part of the tumour, did not appear in any instance to be connected with the walls of the alveoli.

The colloid matter consisted of a hyaline matrix, dotted with fibrinous and fat granules, and had embedded in it a variety of corpuscular and cell forms; Plate VIII.

The following were the various forms seen :—

1. Irregularly spherical corpuscles, about the $\frac{1}{1500}$th of an inch in diameter, without nuclei, and little affected by acetic acid, Fig. 1, *a*.

2. Spherical, oval, and elongated corpuscles, studded with refractive granules, exhibiting distinct outlines, and having an average diameter of $\frac{1}{900}$th of an inch. Some of the corpuscles

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were nucleated; the majority of them contained in each cell, disappeared under the action of hot æther, Fig. 1, *b*.

3. Compound cells, containing several vesicular nuclei or parietal cavities, from which they had been extruded: forms various, Fig. 1, *c*.

4. Fusiform cells, about $\frac{1}{300}$th of an inch in length, and $\frac{1}{1400}$th of an inch in breadth, pointed or bifurcated at one or both extremities, and each containing one or more oval-flattened nuclei. Some of the larger cells of this kind were studded with drops of oil, and appeared to be distended, with a limpid fluid, Fig. 1, *d*.

5. Free broad cells, mostly of a spherical form, with a thick, but distinct outline, filled with nucleated cells, and having an average diameter of $\frac{1}{600}$th of an inch, Fig. 1, *e*.

6. Large spheroidal cells, few in number, about $\frac{1}{500}$th of an inch in diameter, containing from ten to thirty ovoidal nuclei, and resembling bodies found in mycloid tumours, Fig. 1, *f*.

The opaque points and nodules found embedded in the colloid masses, consisted of heaps of compressed cells, abundantly studded with particles of fat. The cells, when separated, were found to vary greatly in size, form, and structure. Some were spherical, some nucleated and entirely filled with fat granules; the majority were either pyriform, fusiform, or branched, and each furnished with one or several vesicular nuclei. These cell forms were analogous to those usually found in medullary cancer.

The walls of the larger alveoli were composed chiefly of true uni-nucleated fusiform cells, united edge to edge, and forming a kind of cellular membrane Fig. 1, *g*.

From the walls of the larger or primary alveoli, bands passed off in various directions forming secondary and smaller alveoli. Three kinds of fibres (?) were found in these bands—the first, tubular looking, dilated at intervals, and containing circular flattened homogeneous particles about twice the diameter of the blood disc* Fig. 1, *h*; the second, fine, dark, and varicose or beaded,

* Probably new vessels. They varied in diameter from 1-1800th to 1-3000th of an inch; and the contained particles disappeared under the action of acetic acid.

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and seemingly composed of oat-shaped nuclei, coherent at their margins Fig. 1, *k*; the third simply fibrous. Some of the tubular looking fibres appeared to terminate in dilated cul-de-sacs, others in free acuminated points or filaments.

From the walls of the secondary alveoli again, other and finer fibres passed off and branched to form alveoli of a still more minute description. The last kind of fibres were either simply molecular (that is to say, composed of molecules arranged in linear form) or branched, and exhibiting a double outline, as if connected with branching cells, or forming continuations of the tubular looking fibres already described.

The general opaque, white, friable portions of the tumour which looked to the naked eye like an early stage of the withering of soft cancer, exhibited structural characters similar to those found in the nodules occupying the centres of the colloid masses. In these parts of the tumour, however, the fibrous areolæ were quite indistinct and free, fat and granule cells were present in greater abundance; the cell forms were more numerous and compressed, and many of them occurring in masses, could not be distinguished from the cell forms constituting cholesteatomatous growths, Fig. 1, *l*.

The tumour which we have just described, is in several respects rare and interesting.

Dr. Andrew Clarke, and
Mr. Wm. Adams, *4th of November*, 1856.

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4. *Unusually large Fatty Tumour from the Back.*

The specimen consisted of the section of a very large fatty tumour, removed from the back of a little girl, æt. between 7 and 8 years.

From the history obtained of the case, it appeared that the mother of the child first observed the commencement of the tumour when she was a year and a half old. The tumour was then quite "a small lump," and the mother was positive as to its non-existence at the period of birth. The growth of the tumour had been steady and progressive, from the period when first

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DESCRIPTION OF PLATE VIII.

Figure 1 illustrates Dr. Andrew Clarke's, and Mr. William Adams's Report on the Microscopic Structure of Mr. Parkinson's Tumour of the Tibia, p. 356.

The tissues are described at length in the text.

Figures 2 to 4 illustrate the Microscopic Structure of Mr. Holthouse's Enchondromatous Tumour, p. 367.

Fig. 2. A group of punctated (with fine oil globules) cells, embedded in a nebulous matrix, from an opalescent, soft, but tenacious material.

Fig. 3. Portion of the same material with water added, shewing a second group of cells with lacunæ in the matrix.

Fig. 4. A nucleated cell, on the addition of acetic acid.

Figures 5 to 7 illustrate Mr. Hutchinson's case of Epulis, p. 380.

Fig. 5. The growth, as seen before removal.

Fig. 6. A section through the growth.

Fig. 7. Microscopic structure of the epulis; a remarkably characteristic specimen of the so-called "myeloid cells."

Figures 8 to 11 illustrate Dr. Sibbald's Notice of Nematoideum Natricis, p. 415.

Fig. 8. Represents the adult female; *a*, the œsophagus; *b*, the intestinal canal; *c*, the uterus, containing ova.

Fig. 9. Shews a portion of the animal, when the intestine *b* has been torn across, and brought into view the two nervous chords, *e*.

Fig. 10. Shews an enlarged view of the head, with the strong muscular œsophagus, *a*.

Fig. 11. Illustrates the development of the embryo—*f*, *g*, *h*, and *i*, ova in progressive stages of development; *k*, the liberated young entozoon.

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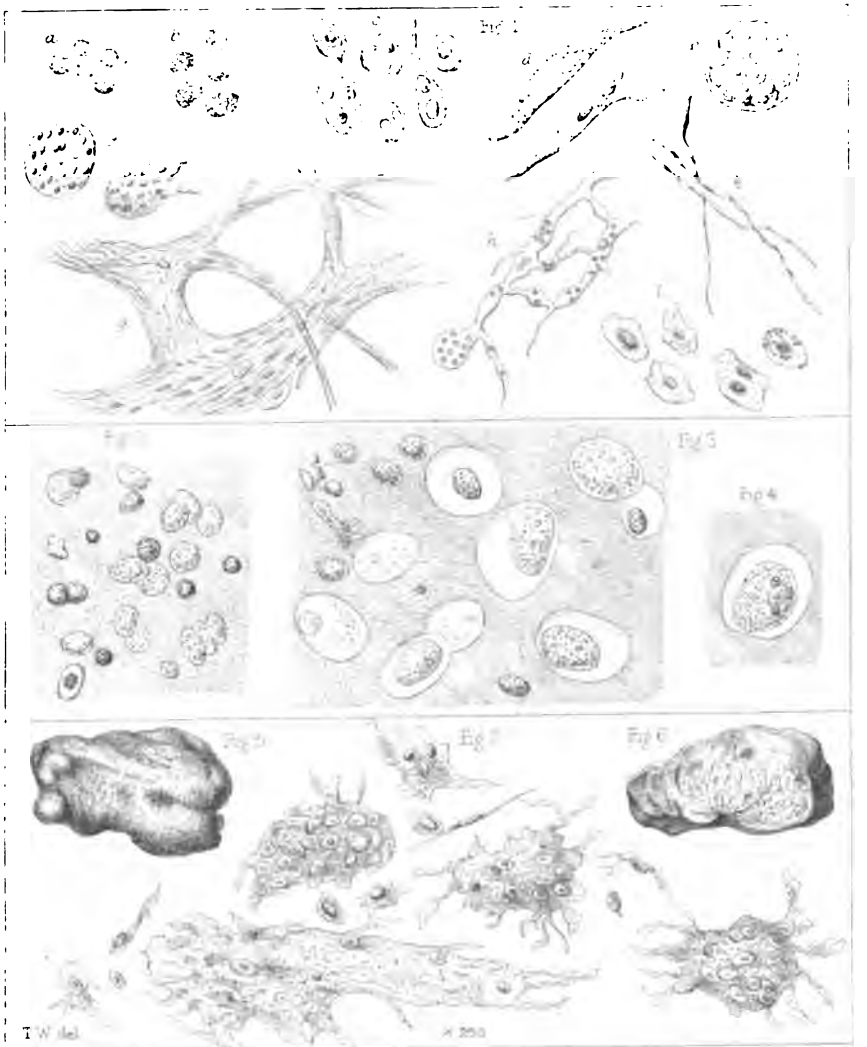

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observed until the time of admission into the Hospital—and the size it had obtained in this interval, indicated an unusually rapid progress in its growth.

The tumour, Fig. 14, previous to its removal, presented a somewhat formidable aspect. The circumference at its base measured twenty-five inches—its greatest circumference was thirty-one and a half inches—from above downwards, twenty-two inches—and from side to side, twenty-eight inches.

Fig. 14.

Represents the appearance and attachments of the tumour. Engraved from a photograph.

The base occupied the right lumbar region; when the child was lying down it spread over the median line of the back, and

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occupied a good portion of the left lumbar region, and also covered the upper portions of the sacral and right gluteal regions. When standing upright, the tumour hung down over the right gluteal region, and its base was dragged down almost to the crest of the ilium by the great weight of the ponderous mass. The base of the tumour itself did not appear to be attached to either vertebræ, ribs, ilium or sacrum; it also appeared superficial to the lumbar fascia, and consequently unconnected with muscle.

The external surface of the growth was marked irregularly by lines of slight depression, mapping out between them bulging portions of the tumour. These latter felt in some spots so dense and hard as to convey to the fingers the sensation of some solid deposit, or of calcareous degeneration having taken place. Large veins, apparently confined to the skin, were observed on the surface of the upper portion of the tumour. The skin in most parts was loosely connnected with the mass below it; but some old cicatrices, and some recent healthy granulating sores, the result of excoriation, were scattered over the middle portion of its surface. The child was in perfect health when admitted into the Hospital, and was able to walk about with surprisingly little inconvenience.

The tumour was removed with very little loss of blood; and as the adhesions between the skin and the growth itself were quite loose and cellular, it was most readily separated from its attachments. The tumour was found to consist of large lobes of fat, of a more solid character than is usually observed in the common fatty tumours of adult life. These lobes were connected together by very firm and thick bands of fibrous tissue, which traversed and intersected the interior of the tumour in numerous directions. The sensation of solid deposit, conveyed to the touch upon examination previous to removal, appeared to depend on some of these bands having contracted upon the lobes of fat, and having thus compressed them most thoroughly into compact, hard, unyielding masses.

The tumour after removal was found to weigh twelve pounds and three-quarters. It did not contain any large vessels, and

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was not more vascular than the usual fatty tumours so commonly removed from various parts of the body. A small portion of the skin in which were situated the cicatrices and ulcers, was removed with the growth.

Mr. Pollock considered this case worthy the attention of the Society, for several reasons:—The occurrence of a fatty tumour at a very early period of life is most rare; in this instance it commenced at about the age of one year and a half. Fatty tumours are usually discovered to commence after the period of adult life, and their growth cannot be characterized as being generally rapid. Mr. Pollock had not been able to meet with a single instance on record of a fatty tumour commencing in infancy. The very rapid growth in this case, in a period of six years, to a weight of nearly thirteen pounds, is also interesting in a structure possessed of low vitality, and free from all large blood vessels. Also the existence of a tumour of this formidable size in a child of seven years of age, having in no way interfered with her health, or with the shape of the spine, which latter was perfectly developed and upright.

The removal of such a large mass from the body of one so young, with impunity to the patient, is practically interesting, and proved that the loss of the growth with but little loss of blood, may be unattended by any shock to the system, and with but very slight constitutional disturbance subsequently.

The child quite recovered and left the Hospital well. A section of the tumour is preserved in the Museum of the College of Surgeons.

Mr. G. Pollock, *4th of November*, 1856.

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5 Old Blood-tumour of the Gastrocnemius Muscle.

In the body of a man, æt. 33, who died of tuberculous pneumonia, in the London Fever Hospital, a great swelling was observed of the right gastrocnemius. The muscle was converted into a cyst that contained about ten ounces of viscid matter, homogeneous, and of a brownish-red colour, not unlike bile; with this were two or three shreds of brown clotty material, filamentous and tufted in texture; these adhered loosely to the

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walls, and where most adherent, they most resembled ordinary blood-clot.

There was very little of the muscular tissue of the gastrocnemius left; the walls of the cyst were formed of a tough membrane which appeared composed of condensed and altered muscular tissue. The lining membrane exhibited white spots, like miliary tubercles with red circumferences, seated on a red transparent membrane in which no vessels were to be distinguished.

Microscopical examination shewed the shreds to be composed of a few nuclei with much granular and amorphous matter, but no blood corpuscles could be recognized; nor were there any hæmatine crystals. (The fluid part was unfortunately not examined while fresh.) The white spots in the red lining membrane exhibited much fat in granules and small globules, but no sort of cell. The walls of the cyst presented very little beyond fat in the same forms, though in some parts muscular fibres, with the transverse striæ hardly recognizable were to be seen. The soleus and plantaris were quite free from disease. The posterior tibial vessels were quite unattached and healthy. There was no previous history of the case.

Dr. Buchanan, *4th of November*, 1856.

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6. *Eight Sebaceous Cysts, removed from one Individual.*

M. S., æt. 48, a cachectic-looking married woman came to me from Strood, and was admitted into Guy's Hospital, on the 19th of December, 1855. For years, she had been troubled with wens on her head and body, but only one of them had been a source of very great trouble. This was situated on her back. It had ulcerated, and had continued to discharge for some months, although she had had it surgically treated. Upon two occasions, a surgeon had applied a ligature around its base, which removed it temporarily.

On the 15th of December, 1855, I removed eight of the growths; five from the head, and three from the trunk. Commencing at the vertex of the cranium, each are described, *vide* Fig. 15.

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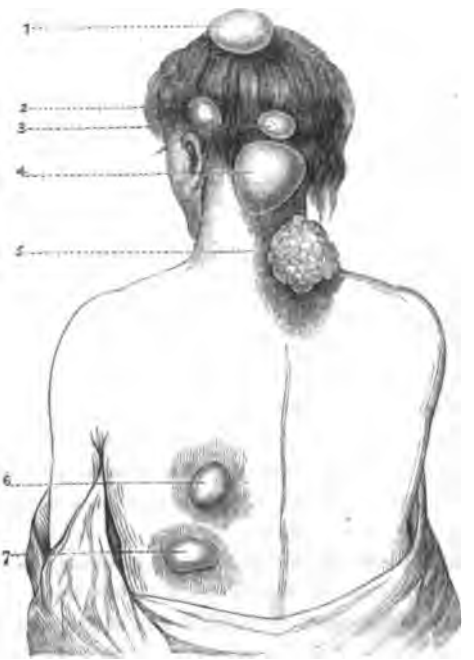
No. 1, was a thin-walled cyst, lined with epidermis scales, which contained yellow sebaceous matter of soft consistence. This consisted of epidermis scales and fatty matter only.

No. 2, situated above and behind the left auricle, had thin walls, was very soft, and contained much yellowish fluid, in which were epidermis scales and fat.

No. 3, smaller than the two described, had very thick, firm,

FIG. 15.



Reprcsents the seven tumours on the back of the head and body, visible at once.

and dense walls; but there was a small cavity in its centre occupied by dry, greasy materials, which were epidermis scales and fat.

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No. 4, the largest, softest and most pendulous of all, had a very thin-walled cyst. It contained scarcely anything more than fluid of a dark colour, resembling coffee-grounds. Adherent to the lining membrane of the cyst was a soft solid, like the fibrine of blood.

No. 5, situated at the summit of the right side of the back, exhibited the external appearances of a fungating cancer. It was somewhat pedunculated, irregular, fissured and lobed on its surface and a secretion of a sero-purulent nature ran from its surface continually. Its attachment was simply dermic, but its arterial supply was rather free, that is, in comparison with all the others. Its elementary composition was epidermic scales, fibre-tissue, nucleated bodies and fatty matter.

No. 6, was developed over the inferior angle of the left scapula. It had a wall of medium thickness, and was filled with sebaceous matter of the ordinary consistence and composition.

No. 7, the most solid and hardest of all, situated at the upper part of the left lumbar region was very firmly attached to the integuments, and the surface was red, as if about to ulcerate. The cyst was leathery, and the entire mass cretaceous.

No. 8, which is not figured in the sketch, was in the scalp, a little in front of the vertex of the head. It was the smallest, had very thick walls of a concentric formation, leathery, almost cartilaginous, and, although containing some sebaceous matter, there was a cavity in the centre.

On this individual we find eight new growths, all exhibiting remarkable diversity in their external, as well as internal physical characters. Such formations and structures, as at one time, would have led morbid anatomists to describe each new growth as a separate form of disease, especially if a formation resembling each of these had been developed upon as many separate individuals.

It would have added very greatly to the interest of the case if an accurate date of the origin of each growth had been procured. In the attempt to do this, I was only suc-

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cessful in discovering that No. 5, the fungating cyst, was the first noticed, and that its period of existence was, at least, twenty years. It had been ulcerated, or fungating, for two or three years. Near the base of its attachment to the skin was a dark-brown warty growth, and a mole had doubtless existed here many years.

Mr. Birkett, 18*th of November*, 1856.

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7. *Enchondromatous Tumour originating in the Left Os Innominatum.*

P. C., æt. 35, a gas labourer, of intemperate habits, was admitted into the Westminster Hospital, under Mr. Guthrie, on the 29th of November, 1853, with a very hard tumour, about the size of a hen's egg, which was firmly attached to the left os innominatum. He left the Hospital unrelieved on the 3rd of January, 1854. On the 28th of November, of the same year, when he was again admitted, it measured nearly six inches in the longitudinal, and four inches in the transverse direction. The left leg was much swollen, and very painful, and the bowels were obstinately costive. He again left the Hospital, but was re-admitted in the early part of the year 1856, and came under the care of Mr. Holthouse, in the latter part of the summer of the same year. His condition, at that time, was as follows:— He was greatly emaciated, and his countenance was expressive of much suffering. He lay constantly somewhat on his left side, his left thigh flexed on his abdomen, and the leg upon the thigh. The foot and ancle were œdematous; he suffered great pain in the limb, and in the abdomen, though pressure on the tumour did not increase the pain. His bowels acted generally once a week; but sometimes ten days, or even a fortnight would intervene, without his obtaining an evacuation, and purgatives and enemata were required for this purpose. The tumour occupied nearly the whole of the abdominal cavity, but its outline could be felt on the right side, and it had pushed the intestines over into the right hypochondriac region, where they could be recognised on percussion. A week or two before his death, a little fluid occupied the abdominal cavity and gravitated to the

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left side, where fluctuation was evident on percussion. The tumour was throughout exceedingly hard and firm to the touch, giving to the hand the sensation as if it were bone. At an earlier period a portion of it was lobulated, but, latterly, it had a more uniform and even surface. Two days before his death he was attacked with pleurisy on the left side, under which he sank.

Post-mortem examination fifteen hours after death. — Great emaciation; no rigor mortis; left foot and ankle œdematous; left leg flexed on the thigh, and incapable of extension; thigh bent on the abdomen. On laying open this cavity, a large tumour was brought into view, which extended upwards to the diaphragm, and downwards, to the floor of the pelvis. Crossing it diagonally, from the left hypochondriac to the right iliac region was the descending colon, the sigmoid flexure of which passed over the brim of the pelvis on the right side, and then underneath the tumour which compressed it, to the anus. The small intestines and ascending colon occupied the right hypochondriac and lumbar regions, and the aorta was pushed over to the right side of the spine, and so escaped compression. The tumour had the peritoneum of the posterior and lateral wall of the abdomen spread over it on the left side, which it had pushed before it as a sort of capsule. On endeavouring to remove the tumour, it was found necessary to remove the lumbar portion of the spine, together with the pelvis, and a part of the tenth, eleventh, and twelfth ribs. After completely detaching this tumour from its osseous connections, it was found to weigh thirty pounds, and to measure forty-two inches in its longitudinal circumference, twenty-five inches and a half in its upper, and twenty-nine inches in its lower. On making a section of it through its long axis, several large cavities, filled with a thick reddish-coloured fluid, were brought into view; the solid portions of the tumour were made up of masses of cartilage of different degrees of consistency, some having the colour and firmness of primitive cartilage, while other portions were softer and resembled colloid cancer; interspersed throughout the mass were numerous opaque patches, of inorganic matter, consisting of phosphate and carbonate of lime, but

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without any trace of bone structure. A vertical section being made through the four lower lumbar vertebræ, sacrum and coccyx, a portion of the tumour was found to have extended into the spinal canal, which it completely filled to the extent of two inches opposite the second and third lumbar vertebræ. A remarkable circumstance connected with this intra-spinal portion of the tumour is, that no paralysis of the right leg was observed during lifetime, and its muscles were as dark-coloured and well nourished as those of the rest of the body, contrasting strongly with the muscles of the opposite limb, which were pale, wasted, and, in some portions submitted to microscopic examination, devoid of the transverse striæ.

Chest.—The cavity of the left pleura was much diminished by the projection of the tumour upwards; recent lymph lined its walls, and the surface of the lung. This organ was dark-coloured, condensed, and œdematous; but contained no tubercular or other deposit. The right pleura pulmonalis and costalis, was adherent throughout, but the lung was crepitant, and free from morbid deposit.

Mr. Holthouse, 18*th of November*, 1856.

Report on the Minute Anatomy of the above-described Tumour.

The tissue, Plate VIII., Figs. 2, 3, 4, consisted of a matrix, with embedded corpuscles. The matrix was nebulous, not fibrous. The corpuscles (cells), were either completely surrounded by the matrix, or were lying loose in cavities (lacunæ) in this latter. These corpuscles varied extremely in size; their form was, in general, either spheroidal or ovoid. They contained no nuclei, but numerous minute oil-globules, which vanished, after the prolonged action of ether. The fibrous tissue separating the lobules of cartilage of the tumour, consisted of ordinary cellular tissue.

Mr. Z. Laurence, 2*nd of December*, 1856.

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8. *Tumour, weighing between six and seven pounds, formed by Encephaloid Disease of the Cervical Glands.*

This large mass was removed, at a *post-mortem* examination,

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from a man who died in St. Thomas's Hospital on the 15th of last November. The man was admitted in the previous July; he was a baker, æt. 40. In February last, that is, about five months previous to his admission, when in the Crimea, a small oval tumour, about the size of a walnut, appeared opposite the left cornu of the hyoid bone. This was followed by other similar tumours developed along the posterior edge of the sterno-mastoid muscle.

At first isolated, they gradually coalesced, forming a large mass which soon involved the surrounding parts: the integument became adherent, and rapidly acquired a dark purplish hue. In the early part of July the right side of the neck began to be similarly affected, and speedily attained a large size. The growth, except when exposed to the sun or wind, was quite painless; both sides rapidly increased in size, and impeded respiration and deglutition. Some short time after his admission, sloughing commenced on the left side, about a couple of inches below the ear, and copious bleedings frequently accompanied the discharge from the ulcerating surface. The frequent recurrence of these quickly undermined the patient's strength, and death took place on the 15th of November. Though perfect respiration seemed impaired, he died rather from anæmia than from asphyxia.

The diseased mass consists of a right and a left portion, separated in the median line by the larynx and trachea, having upon them healthy thyroids. The right half is lobular, and its origin in the cervical glands is very evident, so also is the inner portion of the left; but in the outer part of the mass on this side are involved the sterno-mastoid and some of the deep cervical muscles, so that its immediate origin is rendered indistinct. Behind and above, the disease had extended to the tonsils, and to the base of the tongue. The tonsils were much enlarged, each being about a couple of inches in length, and about three-quarters of an inch in thickness: they were soft and brain-like, and yielded a copious creamy-juice. The circumvallate papillæ were also much enlarged: each was about the size of a pea, and infiltrated with a white, soft, and juicy material.

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The larynx and trachea were healthy their calibre being but very slightly diminished; viscera of thorax, healthy. The mesenteric glands varied in size from a pea to a large walnut, they were soft and brain-like. Each kidney presented five or six whitish cancerous masses, in size from a nut, downwards. The axillary glands were enlarged, and affected with encephaloid. The glands on the right side of the neck, the tonsils, circumvallate papillæ, the axillary, and the mesenteric glands were soft and brain-like, breaking up readily on pressure, and yielding a copious creamy-juice on scraping the cut surface.

A microscopical examination of this juice shewed nuclei, for the most part round, but occasionally oval; the former being about the size of a blood corpuscle, the latter somewhat larger; each having a nucleolus, which was more distinct usually in the oval than the rounded form.

In the above-mentioned places the tissue was made up entirely of these nuclei, no stroma being detected in which they were embedded. On the left side of the neck the tumour cut rather crisply, somewhat like a potato. It also yielded a creamy-juice, but to a less extent than the other masses. Nuclei were found in great abundance of the same size and shape as the above, embedded however in a fibrous stroma. The fibres composing this stroma were exceedingly delicate, interlacing freely in all directions, and leaving here and there interspaces occupied by nuclei.

The masses in the kidneys yielded very little juice, and that of a watery character. They belonged rather to the scirrhous variety of cancer; the nuclear element being occasionally, but sparingly present. Their tissue consisted of an imperfectly fibroid material, of a highly refractive character.

Dr. Sydney Jones, *2nd of December*, 1856.

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9. *Fibroid Growth from the Arm.*

My friend Mr. William Williams, of Dolgelly, sent me a tumour he had removed a few days before from a man in that locality.

R. J., æt. 53-4, a very strong, healthy, robust man, had ob-

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served five or six years since, a small moveable lump beneath the skin, over the left deltoid muscle. Its growth was not rapid until about a year since, when without any assignable cause, it rapidly enlarged, became of a purplish colour, and seemed disposed to ulcerate at its most depending part. He remembered receiving a severe blow in the region twenty-five years before. The tumour was excised by Mr. Williams, on the 13th of November, 1856.

The tumour weighed more than a pound, was of oval shape, and at one part the integument seemed as if about to ulcerate. It consisted of a new growth covered with healthy integument, and at its posterior surface there were small portions of the deltoid muscle. The disease was confined to the integuments, and had not penetrated the fascia covering the deltoid muscle, but it was growing from and firmly attached to this fascia. The muscular fibres were quite healthy.

A section of the new growth exhibited a succulent surface of a somewhat greenish-yellow tint over the larger portion of its surface; but at that part of the tumour where the skin seemed to be ulcerated and infiltrated the surface was white, and milky juice was expressible. The juice from the rest of the tumour was like serum. The elements were elongated, fusiform, nucleated fibres, coherent and very clear and sharp. Their characters are clearly illustrated in Vol. vi. "Path. Trans.," Plate XVI., Fig. 6.

Mr. Birkett, *2nd of December*, 1856.

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10. *A case of Adenocele of the Female Breast.*

R. L., æt. 36, was admitted into Guy's Hospital, under Mr. Birkett, on the 13th of August, 1856. She came from a town in Essex. Her general health had been indifferent for several years, and she evinced indications of the strumous diathesis. She had given birth to two children. Six years before she came to Guy's and a few days after her first confinement which was a good one, her right breast became swollen and painful, and in course of time an abscess was de-

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veloped and opened by a surgeon. The wound healed but a little black spot remained, which enlarged while she was pregnant with her second child and became very much inflamed. In a few days two openings formed, and a great quantity of pus mixed with milk was evacuated. These ulcerated openings were enlarged by a surgeon and they soon afterwards healed. About two years since the breast began again to enlarge, since which progressive increase has taken place. Various ointments have been applied to it without benefit.

She was a delicate, cachectic woman, but calm and resigned in disposition. In the region of the right breast there was a large pendulous vascular growth which seemed to have taken the place of that organ. Its base was much constricted where it was continuous with the integuments of the chest. Its surface was of a brilliant red tint where there were very luxuriant vascular granulations, and, here and there, a few yellow patches like deposits of lymph. In one part there was an open cyst and, springing from its walls, a succulent, vascular growth. A considerable discharge of a sanious, sero-purulent nature was secreted upon the surface, the odour of which, although faint and disagreeable, was not really offensive. The entire mass was distinctly divided into lobes and lobules. When the growth was raised from the chest, the nipple might be seen beneath it at its inferior border, and the whole was encircled by a border of integument which covered about one-third of the mass. Along the edge of this ulcerated opening in the integuments there appeared to be very little disposition to cicatrization; but the growth and the integuments were adherent, the latter being somewhat inverted. The circumjacent veins were much dilated, especially those between the tumour and the clavicle. The aspect assumed by the disease when the patient was admitted had existed a few months only, for when seen by Mr. Cock several months before, it exhibited the ordinary characteristics of adenocele. The axillary glands were healthy. The left breast seemed perfectly healthy although very flaccid and atrophoid.

Her teeth were very much decayed and of a dark colour. The tongue was covered, especially at its sides, with diptheritic

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ulcers, and it was very red. Her bowels were constipated. The catamenia had not appeared the last ten months. Suitable medicines and diet were administered to improve her general health, which was greatly restored in spite of a profuse discharge, and occasional hæmorrhages from the surface of the growth, and on the 20th of August, Mr. Foster removed it by making two elliptical incisions. It was so completely identified with the mammary gland that it was impossible to excise the tumour without sacrificing a portion at least of that organ, and the nipple and lower half were accordingly removed with it. The hæmorrhage was not profuse, although several vessels required ligatures. The wound healed favourably and the patient left the Hospital in twenty days, greatly improved in health and strength.

An examination of the new growth demonstrated all the characteristic appearances of adenocele or the "chronic mammary tumour" of Sir Astley Cooper. It consisted of lobes and lobules loosely connected together by fibre-tissue, with fissures and cystoid formations, from the walls of which the peculiar crenated lobules of gland-tissue sprouted. The elementary structure of the mass, when examined with the microscope, was identical with these tumours.

The natural history of this very interesting case seems to be this:—The patient was for some months troubled with ordinary milk abscesses at two separate confinements. In all probability the new growth was developed perfectly independent of these affections. Its precise date of origin could not be accurately ascertained; but two years, before my observation of it, was stated as about the time when the enlargement was first noticed, and which had progressively increased. From the weight and pressure of the mass, ulceration of its envelope and of the skin took place, and the growth being thus set at liberty, grew rapidly and being well nourished with blood, maintained its vitality like the mammary gland itself, when deprived of its integumental covering by the gangrene of that tissue.

To the casual observer, what disease could in its external appearances more closely resemble, open, ulcerated cancer? The

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worn-out, cachectic, sallow, exsanguine aspect of the sufferer would confirm this opinion, and her age and the history of the progress of the disease would have almost precluded surgical interference.

A point of great practical interest is involved in such a case as this, and I cannot avoid suggesting, that in all probability those cases asserted to be cancer, which, after being treated by reputed cancer curers, have never returned, were cases of this nature.

Mr. Birkett, *2nd of December*, 1856.

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11. *Large irregular Tumour, partly Enchondromatous, situated at the Lower End of the Right Femur and nearly encircling the Bone.*

The tumour had been removed by amputation above the middle of the thigh, on the 19th of November, from a gentleman, æt. 27, of delicate habit, but apparently healthy constitution. The tumour had been growing for about fourteen years, having been first noticed when the subject was thirteen years of age. Its first appearance was in the form of a small, pointed, hard, and, as it was supposed, bony growth, about two inches above the outer condyle. Though first noticed after a trifling accident at school, there appears to be no ground for the belief that the tumour was the consequence of any injury. Nor could any cause be assigned for it. As the growth was slow, and unattended with pain, or interference with the use of the limb, its increase does not seem to have attracted much attention, until about two or three years ago, when the appearance of a similar growth above the inner condyle prevented the indulgence of riding on horseback. Still the growth of this hard part of the tumour appears to have been very slow and painless.

For the last six or eight months, however, the increase of swelling had been more rapid, and considerable pain was occasionally felt, referable, apparently, to the tension of the nerves and tissues around the tumour. This increase was chiefly in an upward direction or in the upper part of the tumour. On

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examination, a few weeks before the operation, the tumour presented the following characters:—

The lower half, or nearly so, of the thigh was much enlarged, being about double the circumference of the opposite one in the same situation. The knee-joint and upper part of the thigh were in perfectly normal condition. A short distance above either condyle a firm, nodulated, irregularly-pointed growth of stony hardness could be seen and felt; and a similar hard, irregular tumour projected in the ham and lower part of the back of the thigh. The parts of the tumour above the outer condyle, and on the back of the thigh, were perfectly fixed; but on careful examination of the part situated above the inner condyle, it felt elastic, and could be moved to a slight extent. In front, the surface of the limb was even and tense, the hard growth apparently not extending over the front of the bone.

The upper portion of the tumour on that part which had been of more recent formation and more rapid growth, differed widely in character from the lower portion. This part, which constituted, perhaps, one fourth of the bulk of the tumour, was tense and elastic, conveying in parts, and more especially on the outer side, an obscure feeling of fluctuation. About a week before the removal of the limb, this part of the swelling had become so tense and prominent and so evidently contained fluid, that a grooved needle was introduced through the somewhat reddened but not œdematous skin, and a small quantity of yellowish or reddish serous fluid allowed to escape. This fluid, on microscopic examination, exhibited nothing but deformed or perfect blood-corpuscles floating in a reddish-yellow fluid.

In the amputation, the bone was sawn across about five inches above the summit of the tumour. Both it and the soft parts were perfectly healthy, although a very large number of vessels required ligature.

The tumour, on dissection, Plate IX., was found to be composed of two apparently distinct portions, a lower and a higher. The lower portion constituting four-fifths of the bulk of the tumour, presented all the external characters of cartilage. The cartilaginous substance, of a white, pearly aspect, was everywhere separated from the surrounding perfectly healthy tissues, by a dry, con-

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densed layer, of connective tissue. The tumour was composed of a congeries of tuberous or botryoidal masses, all more or less rounded, and of various sizes, from that of a walnut, or larger, to that of a pea. The density of the cartilage was such as almost to equal that of bone, though it was readily cut with the knife; and, in the external parts of the tumour, it contained no admixture of earthy matter. Each tuber, examined separately, was highly elastic, and apparently fluctuated, as if it contained fluid; and, when cut into, the cartilaginous substance of which it was composed, was found to diminish gradually in density, from the very firm and solid cortical part to the centre, which was semi-fluid or gelatinous, retaining throughout, its pearly whiteness and semi-transparency, even where quite solid. The softer internal cartilage, however, was not homogeneous, but apparently subdivided into small rounded masses, projecting towards the interior.

Towards the interior of the tumour the mass was more dense, and the structure altogether confused, discoloured, and more or less opaque in parts; and here and there, as the central portion was approached, bony matter was deposited in the cartilage, in irregular granular particles and masses, which became more and more abundant, until, at last, the stem whence the whole tumour appeared to spring, was constituted of a bony growth. This arose from the back of the femur, in the line of the linea aspera, just above the point where it divides into the two condyloid lines. From this central point the growth arose in two vast lobes, on either side of the femur, overlapping it slightly in front, where they almost met. The internal lobe of the tumour was subdivided into two portions—the lower of which being connected with the rest only by a circumscribed base, admitted of considerable movement, when freed from the surrounding parts. But, where these lateral portions of the tumour were in close contact with the bone, the periosteum of the latter was wholly unaffected, being, like all the other contiguous tissues, separated from the tumour by the condensed dry layer of connective tissue noticed above.

The upper, soft, and more rapidly growing portion of the tumour, occupied its summit on both sides in pretty equal pro-

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portions. It appeared to be distinct from the enchondromatous portion and no transitional formation between the two could be perceived. This part of the tumour was of a soft medullary consistence, surrounded with a capsular investment of condensed connective tissue, and when cut into, it appeared of a yellowish, in parts brownish hue, and spongy texture. The vacuities from whose presence the spongy character was derived, were apparently filled with blood-coagula, mostly discoloured and of old date, and at the part, where, previous to the operation, the fluctuation and prominence were most marked, and, where the puncture had been made, a very large cavity of this kind, filled with a discoloured fibrinous mass, resembling the contents of an old aneurismal sac existed. The popliteal vessels passed in front of the internal lateral lobe of the tumour in a shallow groove.

Microscopical examination of the cartilaginous portion disclosed in the dense external layers of the botryoidal masses the usual structure of soft enchondroma, that is to say, a firm, wavy, striated matrix, containing the bodies known under the name of cartilage cells, or nucleiform corpuscles, surrounded with a condensed transparent substance. In some parts these cells were closely crowded, in others, more sparely dispersed; in the softer and more internal part of the cartilage, the matrix no longer presented the wavy-striated, or pseudo-fibrillated aspect exhibited in the more external part, and the nuclei became less manifestly surrounded by any altered substance, and were larger and less uniform in size and shape, many being elongated, caudate, or fusiform. In the interior gelatinous or semi-fluid portion, the only morphological elements perceptible were nuclei of various sizes, free and floating; some quite transparent, others faintly granular; whilst others presented a more marked appearance of granulation, and contained, besides, numerous highly refracting minute spherules or nucleoli. These nucleiform bodies were lodged in a clear, transparent, semi-fluid, homogeneous jelly. The whole conveyed the impression that the soft interior portion of the cartilage was in an immature condition, and that it became gradually consolidated by a process of differentiation into the denser external solid material.

This observation, however, applies only to the soft contents in

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DESCRIPTION OF PLATE IX.

The figure represents the Lower Portion of the Femur, with the Tumour attached, in Mr. Busk's case of Large Irregular Tumour, partially Enchondromatous, p. 375.

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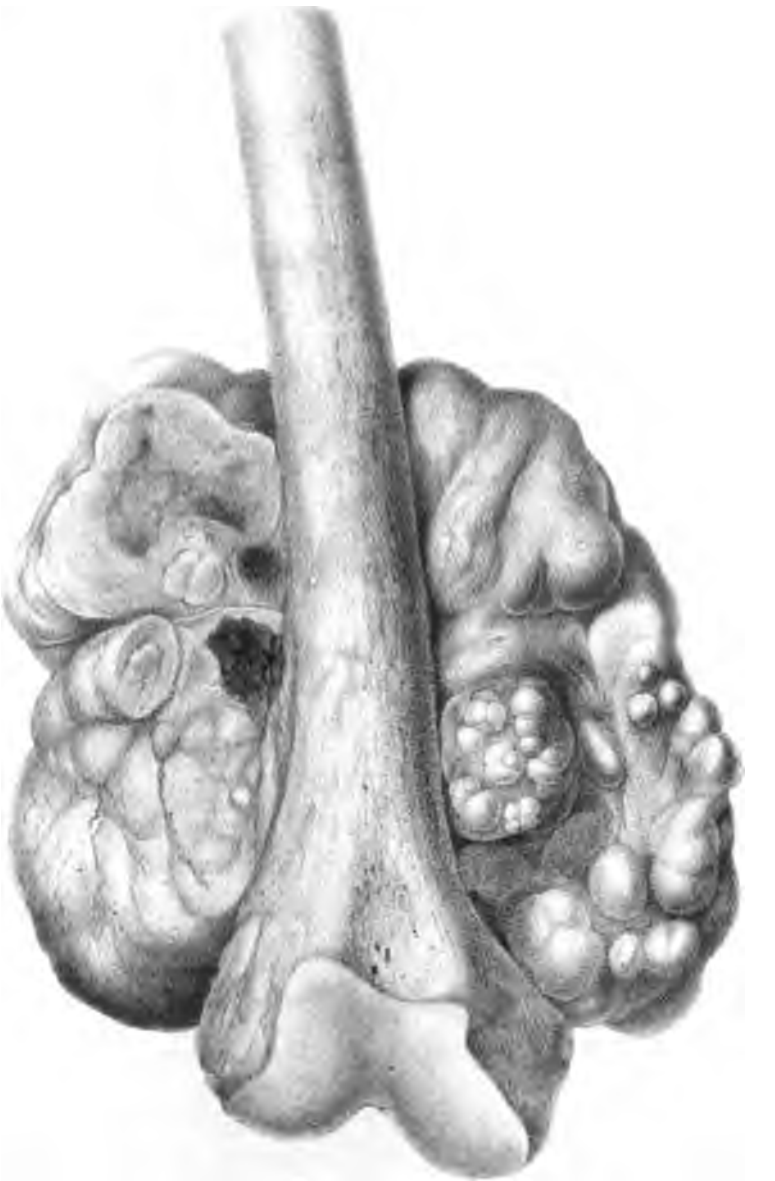

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the recent or superficial botryoidal eminences; because in sections made deeply into its substance, numerous soft parts were observable in which the cartilage appeared to have undergone a process of degeneration. The soft material in these parts was characterized by its yellowish colour, and by the apparent traces of fatty atrophy discernible in its constituent nuclei and cells. The soft medullary substance of the upper part of the tumour appeared to consist wholly of minute fusiform nuclei, and might perhaps be deemed to represent an imperfect or immature connective tissue-growth containing numerous cavities in which blood had apparently been poured out. As it was not injected, it is impossible to say whether it contained vessels of new formation or not. This tumour, part of which appears to be of the kind termed cystic enchondroma, is interesting from its large size, slow and painless growth and the association in it of two apparently quite distinct kinds of tissue.

Mr. G. Busk, *2nd of December*, 1856.

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12. *Tumour from the Flexor Tendon of a Forefinger.*

This tumour was about the size of a walnut, and had been removed by Mr. Spencer Wells, from the forefinger of an old lady, by carefully dissecting it from the sheath of the flexor tendon.

When fresh, it was of soft, gelatinous consistence, and ruddy hue. To the naked eye it appeared to be composed of a uniform substance, arranged in lobules, having very fine enclosing membranes. These were in close and immediate apposition with each other, and without any appreciable amount of common connecting tissue. Very fine blood-vessels traversed the substance of the tumour in considerable abundance. The specific gravity of the tumour was 1·022.

Microscopic specimens, preserved in glycerine, were also shewn. The elements were uniform, consisting of:—

1. Small naked nuclei, generally of oval form, sometimes more elongated, and sometimes uniform.

2. Oat-shaped, spindle-shaped, and filiform elongated cells, with distinct nuclei swelling out the cell at the part where they

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lay. These cells were for the most part clear and transparent, and sometimes appeared to contain two nuclei; and they very rarely presented any granular degeneration.

3. A fine granular or molecular basis substance, sometimes approaching fibrillation, and sometimes almost hyaline.

In general microscopic appearance, the texture of this tumour was very like the young nucleated blastema of fibrous tissue, in the earlier and progressive stages of its development; yet there was no general resemblance to the fibroid, recurrent-fibroid, fibro-nucleated, or fibro-plastic tumour, obvious to the naked eye. Its specific gravity also was peculiar. It approached, in character, some of those forms described as transitional to cancer, much more nearly than to any form of tumour of an entirely innocent nature. But, taking into consideration its lobulated character, its rudimentary structure, and the frequent occurrence of enchondroma on the fingers, it might be an enchondromatous tumour in its early condition.

Much has yet to be done in determining the specific gravity of tumours after their removal. In forming an opinion as to the character of tumours in the living body, especially when they are pendulous, surgeons attach great importance to their weight and density, but their specific gravity after removal has not been ascertained with sufficient care.

Mr. Spencer Wells, *6th of January*, 1857.

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13. *Myeloid Epulis of the Lower Jaw, with Enlarged Glands.*

The patient was a pale, cachectic man, æt. 30. The tumour was about the size of a small walnut, and was placed in the gum of the left side of the lower jaw, in the site of the first two molar teeth. Its exterior was rounded but nodular, being of a purplish-mottled colour. On its inner side was an ulcerated patch, which had often bled freely. The tumour had a broad base, and was firmly fixed to the alveolus. Under the jaw was a gland slightly enlarged, and somewhat tender on pressure. The tumour had been growing for about a year, and had been liable to bleed occasionally for more than a month. There had been pain in it, especially of late, but never of a severe or character-

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istic degree. The man had been seen by several surgeons, more than one of whom, judging from the aspect of the growth, its ulceration, and proneness to bleed, taken in connection with the man's cachectic state, and the enlarged gland, had considered the disease malignant, and had discouraged operative interference. He was now under the care of my friend Mr. M'Whinnie, by whom he was sent to me for an opinion. We agreed in considering the disease as the more vascular form of epulis, and thinking it desirable to remove it, the operation was performed by Mr. M'Whinnie in the latter part of November. Curved bone forceps were used and the alveola from which the tumour grew, was freely cut away together with all the gum which was involved in it.

On examination, the epulis, Plate VIII. Fig. 5, presented all the characters of myeloid growths in a most marked degree. Its section, Fig. 6, was very vascular, and shewed hues varying from a deep red to buff, and a peculiar light-greenish tint of yellow (Xanthoid of Lebert). Scattered in its structures were some detached masses of soft, spongy bone. Under the microscope, were seen abundance of the large poly-nucleated bodies characteristic of these growths, many of them being very irregular in shape, and much branched, Fig. 7. After the operation, the wound healed well; but whilst it was healing, the gland under the jaw somewhat increased in size. Subsequently, however, the gland subsided, and, when last seen, the man was in good health, and there were no indications of a return of the disease.

This specimen was not brought before the Society on account of any supposed rarity of the myeloid form of epulis, but as of interest in respect to the very close resemblance to malignant disease which some of its features presented. There was the marked cachexia of the man, the ulceration of the tumour, and the enlarged gland. In the occurrence of gland-enlargement the case reminded me of one which I brought before the Society at a former meeting, and in which enlargement of the glands took place in connection with a tumour of the humerus, originally of myeloid nature, p. 346. In that, the disease had evidently been of mixed nature, a sort of connecting link between myeloid and true cancer, and, bearing in mind the extreme infrequency of

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disease of the lymphatic system in cases of simple myeloid, I was fearful, in the present instance, that the subsequent events would rank it also in the same category. Nor is, indeed, the period which has elapsed sufficient to make us confident that such may not yet be the case. Should no recurrence ensue, the most probable hypothesis will be, that the enlargement of the gland under the jaw was from simple irritation, and was due, not to the tumour itself, but to the accident of its ulceration.

Mr. Hutchinson, *6th of January*, 1857.

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14. *Malignant Growth of the Fibula.*

A little girl, æt. 8, was admitted into Guy's Hospital, under Mr. Hilton's care, on the 14th of January, 1857, with a very large growth from the left fibula. The history given was that two years since, without any assignable cause, a swelling appeared, on the outer side of the leg, just below the knee, that it gradually increased in size, and, at the end of a twelvemonth, in consequence of its suspicious appearance, amputation was recommended; this, however, was refused by the parents, the child being in very good health. The little patient did not complain of any uneasiness in the mass until six months ago, since which time she has been prevented from walking, and it has been occasionally painful, and rapidly increased in size: several glands in the groin have also become enlarged. The child appearing to be suffering constitutionally, and becoming rapidly emaciated, the friends requested immediate amputation, which was performed, on the 20th of January, by Mr. Hilton, in the lower third of the thigh.

The specimen presented a large unequable mass, occupying the whole length of the outer side of the left leg, from the knee to the ankle-joint extending forwards and backwards, so as almost to include the tibia, and was rather larger above than below. Upon making a longitudinal section, the peronei muscles were seen spread over the surface of the tumour; there were interspersed amongst the mass, portions of bony structure, and the whole presented the appearance of well-marked medullary cancer, involving almost the

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entire length of the fibula. In several places it had encroached upon the tibia, which was bent, but not involved in the growth. The extremities of the fibula were singularly exempt from the disease, which appeared to be arrested by the epiphyses.

Mr. J. Cooper Forster, *20th of January* 1857.

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15. *Report on the cause of death of M. A. C., a woman with a large Malignant Tumour of the Thigh, for which amputation was performed at the Hip-joint.*

In this case, which is recorded in the seventh volume of the Society's "Transactions," the amputation was performed on the 4th of March, 1856, and the woman died at Newbury, on the 25th of December following, having survived the operation nearly ten months. There was dulness over the right side of the chest for some weeks before death, and she suffered severely from pain there. The left lower extremity was also swollen and œdematous. The body was examined on the 28th, by Drs. Bunny and Palmer, of Newbury, who kindly furnished me with the following particulars. The heart, kidneys, and left lung were free from any important disease, and there was no affection of the bronchial, mesenteric, or lumbar glands. The right side of the chest contained an immense cyst, filled with a substance described by these gentlemen as medullary. The left lung was compressed by this mass quite flat. There was no disease of the ribs or intercostal muscles. The liver was displaced and flattened, extending over the abdomen down to the ilia on both sides; its appearance was mottled. Portions of the right lung, and of the liver, sent up to me for examination, were found quite free from any abnormal deposit. A portion of the soft mass removed from the right side of the chest was carefully examined by Dr. A. Clarke, who found it to consist of softened and degenerating lymph. It contained innumerable compound granule cells, free fat, fibrillated tissue, and amorphous granules of phosphate of lime. There was no evidence of malignant disease. The mouth of the uterus was blocked up with a gelatinous polypoid growth.

The rare circumstance of a collection of carcinomatous matter occurring between the two pleuræ, and especially the absence of

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secondary deposits in the lungs, liver, and other parts induce me to concur in the conclusion indicated by the microscopic examination, that the large morbid mass found in the chest was an unusual accumulation of lymph, and not a malignant growth. Such a conclusion, if well established, would be highly satisfactory, as affording encouragement to a repetition of so important an operation under like circumstances, since, under more favourable conditions of health than existed in this woman, a much greater prolongation of life might have been the result.

Mr. Curling, *3rd of February*, 1857.

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16. *Specimen of Adenocele of the Breast; eighteen years' growth. Removal by Mr. T. Muriel, of Hadleigh.*

A married woman, æt. 31, had a tumour, which had been growing in the left breast for eighteen years. She had given birth to a child five years ago. The catamenia had appeared regularly since that time, and, at each period, there was increased pain in the tumour, with slight enlargement. The growth seemed to have been first developed coincidently with puberty, that is, when the girl was thirteen years old.

The tumour was removed by Mr. T. Muriel, of Hadleigh, in Suffolk, on the 29th of November, 1856. It was slightly adherent to the mammary gland, and in relation with its superior lobes.

The tumour, about three inches in diameter, was very dense, and closely surrounded by a well developed fibrous envelope, and consisted of lobules, loosely connected together by the ordinary connective tissue.

The lobules were composed of the terminal cæci of the gland tissue, which contained epithelium.

The new growth, in its general external appearance, and in its minute anatomy, as nearly as possible, resembled the structure of the breast itself. The remarks upon this case will be included with those upon the next case, (No. 17.)

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17. *Adenocele of the Breast; four months' growth. Removed by Mr. Teale, of Leeds.*

A married lady, æt. 56, had observed a lump in the right breast for four or five months before it was removed by Mr. Teale. She had borne eleven children, and suckled six, the last twenty-two years since. The catamenia have ceased fourteen years.

The tumour was globular, nodulated, about four inches in diameter, and situated among the sternal lobes of the gland. It produced a slight elevation above the plane of the surrounding parts. Acute pain was never felt, but intermittent, dragging, aching sensations were experienced. The patient's general health was very good. The axillary glands were not affected; there was no history of hereditary predisposition to the formation of new growths.

A portion of the gland was removed with the tumour. They were very loosely connected together. The new growth was composed of a cyst and solid growth. The cyst contained sero-sanguineous fluid. The solid part consisted of lobuli projecting from small cells or cysts minutely divided, and but loosely attached. The solid mass was about two inches and a half in diameter. The minute divisions of the growth were composed of the cœcal terminations of the ducts.

Mr. Birkett, *3rd of February*, 1857.

Remarks.—In these two cases we have examples of two forms, in which adenocele is developed in the breast.

1. The dense, close, fibrous variety, closely invested by a fibrous capsule, and exhibiting all the external characters of a supernumerary mammary gland, except the ducts or excretory portion of the organ, for the secretory portion is well formed.

2. That variety which is so commonly associated with so-called cysts, and, in which the growth is loosely connected together, the lobuli being, therefore, very clearly marked, and projecting from what is termed, in this example, the wall of the cyst. If the cyst wall had been united by connective tissue, with the growth, it would have been called the fibrous envelope of the tumour.

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In the first example, the growth is very slow, and therefore, advances progressively, the connective and gland tissues becoming equally developed, and both reaching an equality of perfection.

In the second example, the growth is very rapid, and the development of the elements of gland tissue advances at a greater rate than that of the connective tissue. In place of connective tissue, we find fluid which insinuates itself between the lobes and lobules of the imperfectly developed gland tissue, and thus separates them from the fibrous envelope, by which, in the examples of more aged and slow growths, they are invariably, closely invested.

Is this serous tenacious fluid, the plasma or formative fluid, from which connective tissue is developed?

Mr. Birkett, *23rd of February*, 1857.

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18. *Fibro-Plastic Tumour.*

The specimen was removed from beneath the angle of the right lower jaw of a boy, æt. 16. It had been growing slowly, but uniformly, for four years; had occasioned little if any pain, and had been treated in the country with the external application of iodine for a great length of a time. The tumour was of about the size of a large walnut, rough, and lobulated externally, extremely dense, and at one lower nipple-like portion, as hard as cartilage. It was loose and moveable, and easily extirpated, its connections with the great vessels of the neck being cellular. On section, it exhibited a dense, opaque-looking structure contained in a capsule; and in its interior were evident marks of former cysts. Its basis was fibro-plastic, being made up of fibre cells and connective tissue in different stages of development, and it also exhibited traces of imperfectly-formed gland tissue. The lower portion contained some true cartilage, associated with the fibrous tissue; and it would seem to have been one of those fibro-glandular tumours in which cartilage may eventually be developed, but which are certainly distinct from the true choroid tumour which forms in connection with bone. These tumours are sometimes called parotid tumours.

Mr. M. Henry, *21st of April*, 1857.

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19. *Myeloid Tumour of the Condyles of the Femur.*

J. S., æt. 15, a gas-fitter, residing at Wandsworth, was admitted into Guy's Hospital, under Mr. Hilton, on the 3rd of April. He had always enjoyed good health till the end of December last, when, without any known cause, his left knee began to swell, but was unattended with pain. The enlargement gradually increased, and stiffness of the joint appeared, with some degree of pain on pressure. He continued, however, at his work, till three weeks ago, when, by medical advice he rested, applied blisters, and took cod-liver oil. The growth then became stationary, and he applied for admission into Guy's.

When admitted he presented a delicate aspect, but his body was well nourished. In the situation of the condyles of the femur, and extending upwards, there was a swelling of a firm, even and tense character, which apparently consisted of dilated bone. The skin was free and not discoloured, but considerable pain was experienced when pressure was applied.

The joint was easily moveable, and was evidently unaffected. A few days after admission, the growth was punctured with a trochar and canula, but blood only escaped. On April the 28th, the thigh was amputated above its middle. On examining the growth, its character became apparent. It had evidently commenced in the lower part of the shaft of the femur, which it had expanded; some part of the shell of bone being now visible, it had encroached partially upon the epiphysis, which was slightly diseased at the line of junction. Some new bone was also visible at the part where it was connected with the shaft.

To the eye the tumour presented the usual features of the myeloid tumour. It was, perhaps, unusually vascular, the cells being nearly filled with blood. When examined microscopically, it also exhibited the large many-nucleated cells, described as characteristic of the myeloid growth.

Mr. Thomas Bryant, *5th of May*, 1857.

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20. *Pendulous Fibro-nucleated Tumour developed on the Skin of the Abdomen.*

J. R., æt. 30, a married woman, residing in Bermondsey, was admitted into Guy's Hospital on the 22nd of April, under the care of Mr. Cock.

Three months previously she received a blow upon the right side of the umbilicus. A few days afterwards she discovered a tumour in this position, about the size of a walnut. This gradually enlarging, she came to Guy's. On admission she presented a healthy appearance, and, in the right abdominal walls, was a tumour, the size of a fist, easily moveable, and raised from the muscles beneath; its surface presented a congested appearance, and, to the hand, it gave a firm and fibrous feel. On May the 5th it was excised, and, microscopically, was seen to be composed of little else than nuclei, with some delicate fibre tissues, evidently belonging to that rare class of tumours called fibro-nucleated. Mr. Thomas Bryant, *5th of May*, 1857.

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21. *Carcinoma of the Head of the Tibia.—Amputation.*

A. L., æt. 32, was admitted into Guy's Hospital under my care, on the 24th of December, 1856, on account of severe pain and swelling in the region of the internal tuberosity of the right tibia. During the third month of her seventh pregnancy, in May or June, 1856, she felt violent pain in the inside of the head of the right tibia without any appreciable alteration in the shape of the part. After experiencing intense pain for about three months, a swelling appeared. She was confined of a living child in November, 1856, and in December, the first time I saw her, she was greatly reduced by parturition, lactation, and intense pain. She had enjoyed good health, was born in the country, and had been a domestic servant, but of late, had been living very low. The knee was semiflexed, and could not be extended without giving intense pain. The swelling was distinctly felt to be beneath the expansion of the inner hamstring muscles, and was immoveably fixed to, and seemed part of, the tibia itself. It was very hard, regular on its surface, and the integu-

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ments were of a normal colour. Neither warmth, moisture, cold, position, perfect rest, nor any means afforded much relief. Cold aggravated the pain; on the contrary opiates afforded temporary relief. She left the Hospital in January, 1857, and came again under my care in April. The growth was larger, the knee-joint more flexed, the pain rather less, the tumour more acuminated, and the integuments over it shining and slightly injected. She weaned the infant, and her general health was a little improved. The inguinal glands were healthy. I punctured the swelling with a small trochar and canula, but only blood escaped, and, on the 5th of May, I amputated through the middle third the femur. A vertical section was made through the head of the tibia, which shewed that its whole cancellous tissue was converted into a firm, fibro-cartilaginous mass, which offered considerable resistance to the knife and to the pressure of the finger-nail. This new growth extended about two inches beyond the contour of the internal tuberosity of the head of the bone, and downwards in the shaft of the bone for about one inch. A turbid, although not milky juice, could be expressed from the growth. Scarcely any bony tissue could be recognized, the cancellous tissue, as well as the compact, being destroyed, and its site occupied by the new growth.

The elements of the growth, examined with the microscope, were nucleated cells with fibre-tissue,—in a word, were those met with in carcinoma.

Mr. Birkett, *5th of May*, 1857.

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22. *Malignant Growth of the Fibula* (*Myeloid?*)

G. W., æt. 18, a leather dyer was admitted into Guy's Hospital, under Mr. Cock's care, on the 13th of May, 1857. He stated that a week after Christmas a swelling appeared on the outer side of the left leg, about the head of the fibula, which gradually increased in size, until it became rather larger than the two fists; there was little doubt as to its character, and the propriety of amputating the thigh for its relief; but he left the Hospital (into which he had been admitted on the 4th of March,) on the 20th of April, and got under the care of a quack, who by means

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of blows, and friction with some stimulating ointment, caused it to attain, from the time he left to the time he was admitted again, double its previous size; it appeared as if containing fluid in various places, and I have little doubt the whole would quickly have softened down and fungated. He suffered very little pain, but in consequence of its great size and inconvenience wished to have the limb removed, which was accordingly done at the lower third of the thigh, on the 19th of May, by Mr. Cock.

Upon making a longitudinal section of the tumour, masses of bone were seen interspersed throughout the whole of the structure, which involved the upper end of the fibula, pressed upon the tibia and had given rise to periostitis of that bone, and consequent deposit of a layer of new bone under the periosteum, upon removing which the tibia was seen of its natural size. The general appearance of the whole tumour was that of encephaloid disease, and the microscope seemed to support the opinion of its malignancy, but here and there were portions which presented cells of a true myeloid character; and I could only come to the conclusion that it was a mixed form of disease, and would most probably return. The rapid increase in size during the last month, seemed to be owing to the development of large cysts filled with blood and serum, which were softening down.

J. Cooper Forster, *19th of May*, 1857.

X. MISCELLANEOUS SPECIMENS, INCLUDING SKIN, ENTOZOA AND MALFORMATION, ETC.

1. *Dissection of a Fore-arm and Hand, after re-section of the Wrist.*

The operation was performed on the 12th of April, 1856. The whole of the bones of the wrist were supposed to have been removed. Dissection shews that the pisiform bone, the trapezium, and a part of the unciform bones had been left. Portions of the radius and ulna were taken away.

The operation was performed through a wound in the soft parts, on the ulna side of the joint. The dissection shews how

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little damage to tendons had been inflicted. The hand moved freely at the wrist, and there was free use of the fingers and thumb. A small sinus remained on both the radial, and ulna side of the wrist, and on dissection it was found that both of the sinuses communicated with a portion of the end of the radius which was bare. The patient died of phthisis six months after the operation.

Mr. Fergusson, 21*st of October*, 1856.

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2. *Microscopic appearances in a portion of Bronzed Skin.*

The patient from whom this specimen of skin had been taken, was a young man who had died under Dr. Baly's care in St. Bartholomew's Hospital. He had suffered for more than three years from bronzed skin and the usual pain of symptoms attending it. Both supra-renal capsules had been found after death destroyed by chalky degeneration. The bronzing of the skin was extremely well marked, and was of the diffused form, the integument generally resembling that of a Creole. A disagreeable odour, resembling that of a negro, had been noticed as exhaling from the patient's body.

The piece of skin brought before the Society, had been kept some weeks in spirit and had changed its tint from a brown to a blue-black, looking much as if it had been stained with lunar caustic. A section of the skin placed under the microscope shewed the rete mucosum occupied by a layer of dark bistre-brown, Plate VI. Fig. 4, which was of tolerably uniform thickness, but much waved to adapt itself to the convexities and depressions of the papillæ. This layer which exactly resembled that of the coloured races, consisted in part of coloured cells and in part of pigment granules. The margins of the coloured layer were abruptly defined, and the epidermis above, and the true skin below, were normal in texture and quite colourless. Mr. Hutchinson adverted to the fact that he believed this was the first demonstration made as to the pigmentary nature of the colouring in bronzed skin, at least in this country; the observation had been confirmed by an examination by M. Robin of Paris. He remarked also that a section of skin sufficiently thin for the purpose was very easily cut, and urged that this method of confining the diagnosis ought

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never to be omitted in this class of cases. He had no doubt but that several cases which he had read in the French and other journals, as examples of bronzed skin, were in all probability pityriasis versicolor in unusually large patches. The microscopic diagnosis between these two conditions was easy, even during the life of the patient, since the fungus of the latter was easily found in the branny scales produced by the desquamation of the cuticle which attends it.

Mr. Hutchinson, *20th of October*, 1856.

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3. *Leg of a Child torn from the Thigh at the Knee-joint.*

The leg was that of a child, æt. 8, which had been torn off from the thigh at the knee-joint, in consequence of its having become entangled in the wheel of a street cab while in motion. The child was taken to St. George's Hospital in the afternoon, and was seen by Mr. Cæsar Hawkins. On examination, it was found that all the leg from the knee downwards had been entirely separated from the thigh, leaving the condyles and articular surface of the femur completely exposed. The surrounding soft parts were pretty evenly cut round, as if a circular incision from amputation had been made at the knee. There was a simple fracture of the femur of the same side, about its middle, with considerable contusion of the soft parts.

The child was in a state of extreme collapse on admission, but, it did not appear that a very large quantity of blood had been lost. There was no hæmorrhage from the lacerated wound, not even from the divided popliteal artery, nor was there any occasion for the application of a tourniquet to arrest bleeding.

A considerable degree of tenderness over the lower part of the abdomen was complained of, on pressure, and this led to a suspicion that some visceral injury had been sustained. The child having slightly rallied in the evening, Mr. Pollock, at the request of Mr. Hawkins, removed the portion of the thigh below the fracture. The tenderness of the abdomen had somewhat increased, and the urine drawn off was found to contain blood. The leg, which had been torn off at the time of the accident, was found by a policeman, and brought to the Hospital subse-

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quent to the admission of the child. The patella was found attached to the tibia, the ligamentum patellæ being perfect; the tendon of the quadriceps muscle having been torn through, to liberate the patella from the thigh. All the ligaments attaching the tibia to the femur had also been torn through. The articular cartilage of all the bones exposed was uninjured.

An interesting point in connection with the accident was, that the sciatic nerve was torn out from the thigh with the leg, and was seen attached to the latter, stript of all surrounding soft tissues, and measuring seventeen inches in length.

The boy died two days after the accident. Much extravasation of blood was observed along the course of the sciatic, and in some of the branches of the sacral plexus, on the same side as the injury. Some of the branches of the sacral plexus were shreddy, and broken off close to the anterior sacral foramina. The sacro-iliac joints were separated, and the pelvis fractured on the right side, through the pubis, into the obturated foramen. A sharp piece of the fractured bone projecting inwards had punctured and lacerated the bladder, and had thus allowed urine to escape into the surrounding cellular tissue.

Mr. G. Pollock, *4th of November*, 1856.

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4. *A Dissected Specimen of Non-Congenital Club-Foot.—Talipes Equino-varus of Paralytic Origin, in which Relapse of the Deformity had taken place after several Operations.*

The specimen exhibited consisted of the left leg which had been removed from the body of G. T., æt. 37, a basket-maker, who died in University College Hospital, on the 19th December, 1856. He was admitted into the Hospital on the 19th of September 1856. His left leg was partially paralytic, and the foot contracted in the form of talipes equino-varus. This had existed from the age of two years, and was said to have been the result of a burn; but no cicatrices existed, and there can be no doubt that he had suffered from infantile paralysis, which had given rise to the contraction and deformity of the foot, one of its most constant and almost invariable results. He had also a contraction of the right knee-joint, which, in the notes taken by the

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dresser, it is said, had been inflamed after a fall, in November, 1852. He went to the Royal Free Hospital, and, afterwards, to Guy's. Suppuration did not take place, and he got well, with a deformed leg. The tibia was partially dislocated backwards, but the joint was not anchylosed. The leg could be straightened to an angle of forty degrees, and flexed to ninety degrees.

In consequence of the paralytic and contracted condition of the left leg and foot, and the contraction of the right knee-joint this man was in a very helpless condition as regards the power of locomotion and could scarcely get about, even with the assistance of crutches. He positively refused to have anything done to the left foot, because he said it had been several times operated upon without benefit; but he consented to an operation being performed on the right knee-joint, and, in the hope of giving the man one useful leg, Mr. H. Thompson excised the right knee-joint on the 1st of October, 1856. He progressed very favourably for the first month, but erysipelas came on, being then prevalent in the ward; he had a severe attack, and several large collections of pus were opened by Mr. Erichsen, and the man died on the 19th of December, 1856. For the opportunity of dissecting the leg and of bringing it before the Pathological Society, I was indebted to the kindness of Mr. Erichsen, in Mr. Thompson's absence from ill health.

History of the treatment of the deformity.—The man stated that he had been in several Hospitals, and that the left foot had been repeatedly operated upon for the cure of the deformity, without success; but the dates of these operations were, unfortunately, not ascertained from him, and, as he died without friends, no information could afterwards be obtained. A very important point, therefore, in the pathological interest of the specimen, in reference to the reparative process in tendon, after sub-cutaneous division, is defective, and it is impossible to say what period after division, or stage of the reparative process, is represented in the conditions exhibited in all the tendons which have been divided and re-divided. I have ascertained, however, that some of the operations, including the division of the tendo-Achillis and the posterior tibial and long flexor tendons, were performed about two years before his death, in Guy's Hospital, by Mr. Cock,

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who had the man a long time under observation, and took a good deal of interest in his case. Mr. Cock has been kind enough to refer to his case-book, and has sent me the following memorandum :—

"In November, 1854, I divided the tendo-Achillis, and also the tendons behind the malleolus internus. In January 1856, I divided, pretty extensively, the plantar fascia, including portions of the muscles."

It is probable that some of the operations, especially one or two divisions of the tendo-Achillis, had been performed long prior to this date, judging from the appearances presented by the new material on section, and especially from the obliteration of the dovetailing appearance presented after the more recent operations, at the line of junction of the old with the new tendon. I should suppose that both the operations on the posterior tibial and long flexor tendons had been performed within a short time of each other, judging from the close similarity presented in the appearances; one of these operations might have been performed before he entered Guy's Hospital, or they might both have been done in that Institution, only one being recorded. It is certainly improbable that he submitted to further operative treatment, after the great attention he received at Guy's Hospital, and when he entered University College Hospital, he peremptorily refused to allow any further operative proceedings on this foot. In reference to the stage of the reparative process, therefore, we may pretty fairly conclude that the two divisions of the posterior tibial and long flexor tendons, and one division of the tendo-Achillis, had been performed about two years previous to his death, and that one or two divisions of the tendo-Achillis had been performed previous to that date.

The external characters of the deformity were such as are ordinarily presented in a case of talipes equinus of paralytic origin, with a slight inclination inwards of the anterior portion of the foot. The inversion was more conspicuous in the specimen than is represented in the Plate, which is taken from a point of view least calculated to exhibit this portion of the deformity, and from which it is difficult to represent it. The inversion of the anterior part of the foot had been well marked, sufficiently so, perhaps, to give the deformity the appearance

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of varus, but had been overcome by the two divisions of the posterior tibial and long flexor tendons. I shall, therefore, record the case as one of talipes equino-varus. The dorsal aspect of the foot was very prominent and irregular, the head of the astragalus especially projecting, and the plantar aspect deeply arched in consequence of the anterior portion of the foot being bent backwards from the transverse tarsal joint, and of the plantar fascia, muscular, and deep ligamentous tissue in the sole of the foot being shortened, and rigidly contracted. The foot, therefore, was very much bent upon itself from the transverse tarsal joint, and the effect of this condition—one of much more frequent occurrence than is generally described—is always to add to the apparent elevation of the tuberosity of the os calcis, and, in such cases, the os calcis is found, upon dissection, to deviate very slightly from its natural horizontal position. It was so in the present instance, as may be seen in the Plate, by noticing the relation of the tuberosity of the os calcis to the malleolus. The toes were flexed, or bent in a claw-like form, as is constantly the case in long standing paralytic deformities, in which all the anterior muscles are paralysed, and the feet have not been used in progression.

Appearances presented on dissection of the leg and foot muscles.—All the muscles of the leg, below knee, were found to be in an extremely advanced stage of fatty degeneration, and of a yellow fatty appearance to the naked eye, except the tibialis anticus, which was of a pale red colour, and apparently but slightly degenerated. All the bellies of the muscles were much atrophied and diminished in size. I submitted every muscle to microscopic examination, and the appearances presented were as follows :—

Tibialis anticus.—To the naked eye, this was the only muscle of the leg which presented anything like a healthy appearance. The belly of the muscle was of a brownish-red colour (browner and lighter than a healthy muscle,) and it looked like a muscle slightly degenerated. In some parts it was mottled with light-yellow patches, as if fatty, and streaked with excess of fat between the bundles of fasciculi.

Microscopic examination.—Not quite healthy in any part, but

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a good deal of tolerably healthy muscular tissue. Fasciculi of normal size. Transverse striæ distinct in many parts, but not so clear as in healthy muscle. In other parts fasciculi very pale, and transverse striæ very indistinct. In some parts the fasciculi were large, pale, and filled with opalescent oil globules, aggregated, so as to give a granular appearance to the contents; this appearance was distinct from the small refractive molecules of oil which existed in some fasciculi, and escaped free in the field. In these degenerated fasciculi no traces of transverse striæ existed.

Extensor pollicis.—To the naked eye, yellow and fatty, except a few narrow bands of light brown muscular tissue.

Microscopic examination. — The light-brown muscular bands exhibited large fasciculi, filled with yellowish opalescent oil globules, and presented a granular fatty appearance. Transverse striæ only traceable in a few places, and then very pale and indistinct. Fatty and fibrous tissue increased. The portions of the muscle, which to the naked eye had a yellow fatty appearance, shewed no trace of fasciculi, but presented the ordinary appearance of fatty substitution, *i. e.*, vesicular fatty tissue, as described by Mr. Quekett, throughout.

Extensor longus digitorum.—The naked eye, and microscopic appearances, precisely the same as in the extensor pollicis throughout; but, if anything, rather more advanced, as the light brown muscular bands presented no trace of transverse striæ.

Peronei.—To the naked eye, yellow and fatty.

Microscopic examination.—Fasciculi of average size, pale, and striæ very faint, containing opalescent oil globules, and having a granular fatty appearance. Molecular oil and fatty tissue abundant.

Gastrocnemius.—To the naked eye yellow and fatty, except the inner head, which contained a good deal of brownish-coloured muscular fibre, intermixed with yellow patches, and separated by a great excess of fatty tissue, so that this portion of the muscle presented a mottled and streaked appearance.

Microscopic appearance.—Inner head, muscular fasciculi very pale, with indistinct transverse striæ. Fatty tissue abundant.

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Outer head; no trace of muscular fasciculi. Fatty tissue, *i.e.*, fatty substitution throughout.

Soleus.—To the naked eye, yellow and fatty, so much so, that the fasciculated appearance of muscular tissue was lost.

Microscopic examination.—No trace of muscular fasciculi. Fatty tissue throughout, like the outer head of the gastrocnemius.

Flexor longus digitorum.—To the naked eye, yellow and fatty.

Microscopic examination.—Muscular fasciculi pale, with delicate transverse striæ. Fatty tissue abundant.

Tibialis posticus.—To the naked eye, yellow and fatty.

Microscopic examination.—Muscular fasciculi only indicated by faint outlines, and filled with yellowish opalescent oil globules, so that the fasciculi had a granular fatty appearance. No transverse striæ. Fatty tissue abundant.

Flexor longus pollicis.—To the naked eye, yellow and fatty.

Microscopic examination.—No trace of muscular fasciculi. Fatty and fibrous tissue throughout.

Accessory muscle to the flexor longus pollicis,(See Plate X. *m*). —The tendon of which, in the foot, joined that of the flexor muscle of the toes, and, by traction, moved the four outer toes, but did not move the great toe. To the naked eye, yellow and fatty, but striated in some parts.

Microscopic examination.—No trace of muscular fasciculi, not even in the best looking parts. Fatty and fibrous tissue throughout.

Tendons.—All the tendons were much below their natural size. The tendo-Achillis presented a flattened, expanded appearance, and was connected on either side with the deep fascia of the leg, by strong membranous bands of adhesion passing downwards from its lateral margins, so that it was impossible to define this tendon by dissection, as in the healthy condition. These membraneous bands of adhesion were no doubt the result of the repeated operations to which this tendon had been subjected, and would materially have interfered with the success of any further division for the purpose of obtaining additional elongation.

The tendo-Achillis, and the posterior tibial tendon, were longitudinally divided. See Plate X., (*a a*,) and (*e e*,) for the purpose

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of examining the relations of the new with the old tendon, and the appearances are well represented in the Plate.

The tendo-Achillis had evidently been divided three or four times, and, at the seat of one of these divisions, the new tendinous tissue appeared to have cut through (letter *d*, in Plate). New tendon was seen to be intermixed with old tendon, a portion of which is represented at (*c*,) through a space of two inches between the letters (*b* and *b*) in Plate; but it was impossible to say exactly how much new tendon had been formed, though, probably, from an inch to an inch and a half.

The posterior tibial tendon had been once divided only half through, above the inner malleolus—a wedge-shaped portion of new tendon existing in this situation, letter *(f)* in Plate, and once completely through, behind the malleolus, (*g*). In the latter situation the divided extremities of the tendon (*h h* and *h h*) had never re-united. A small quantity of new tendon had formed in connexion with each of the divided extremities; but towards the centre, each portion of new tendon was firmly adherent to the anterior wall of the dense sheath (*i*,) behind the malleolus.

The new tendinous tissue was readily distinguishable from the old tendon at the upper extremity, by the difference of colour—the new tissue (*j*,) was of a greyish translucent appearance—and by the abrupt line of demarcation; but no such distinctions existed at the lower extremity, and it seemed as if very little new tendon had been formed in connexion with the inferior extremity of the divided tendon.

This tendon, therefore, at once afforded an excellent example of the non-union of divided tendon, and also of partial division of the posterior tibial tendon, the sub-cutaneous section of which is more difficult than some surgeons might suppose. Non-union of a divided tendon is probably a very rare event, except when the operation is performed in the dense portion of the sheath, as in the present instance, because in this situation there is an absence of the loose cellular sheath and areolar tissue which surrounds the tendo-Achillis and other tendons in the situation usually selected for operation, and falls in between the divided extremities which they serve to connect, and at the same time

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form the matrix in which the reparative material is effused. The long-established practical rule at the Orthopædic Hospital is never to divide a tendon whether in the hand or the foot, in the dense portion of its sheath, the fear being of adhesion and impaired mobility, but the greater danger is evidently non-union.

The tendon of the flexor longus digitorum muscle had been twice divided at points corresponding to the operations on the posterior tibial tendon. Seven-eighths of an inch of new tendon (letter *k*,) connected the divided extremities of the old tendon at the superior operation; and one inch and an eighth of new tendon (letter *l*,) connected the divided extremities of the old tendon in a similar way, at the seat of the inferior operation. It is worthy of remark that in both situations the whole of the new tendinous tissue had been formed below the line of incision made at the operation, as proved by the fact that the junction of the new tendon with the superior divided extremity of the old tendon at the highest operation in the flexor longus, exactly corresponds to the partial division of the posterior tibial tendon (letter *f*,) and the new tendinous tissue is all below this point. When healthy muscles are operated upon, as in experiments on animals, retraction of the superior divided extremity of the tendon takes place, and the new tissue is formed partly above, and partly below the seat of division. In the leg now exhibited no separation could have taken place at the seat of the partial division of the posterior tibial tendon (*f*,) and therefore the exact line of the operation is still indicated; and with this line the superior divided extremity of the flexor longus tendon still corresponds. The advanced state of degeneration of the muscular tissue above described, sufficiently explains the absence of muscular retraction and drawing upwards of the superior extremity of the divided tendon. The length of new tendon must therefore indicate the extent to which the foot had been restored towards its natural position, and it is certain that the inversion of the foot must have been very severe, the case probably having been one of complete varus, though now very little inversion exists, and it might almost be called a case of equinus.

The new tendinous tissue inserted into, and elongating the

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tendon of the flexor longus digitorum muscle, presented to the naked eye a greyish, translucent appearance, and was thus readily distinguishable from the opaque, glistening, yellowish-white old tendon; it formed a cylindrical cord connecting the divided extremities of the old tendon, and in diameter was nearly, but not quite equal to the latter.

Microscopic examination of the new tendon.—Portions of the new tendon from all the situations in which it had been formed, were submitted to microscopical examination, and presented the same general characters as have been described by myself as existing in the newly-formed tendon in rabbits after subcutaneous divisions, and complete reparation. See "Transactions of the Pathological Society," Vol. VI., and the drawings in Plate XVIII of the same Vol. :—also "Medical Times and Gazette" for January 12th 1856. In the situations in which the new tendon appeared to have been of the oldest date, the fibrous tissue was seen to be still of a much more delicate character than in the old tendon.

Ultimate disposal of the newly-formed tendinous tissue.—The appearances presented in this specimen are of great pathological interest in reference to the question of the ultimate disposal of the newly-formed connective tissue, or as it may properly be called new tendon. The length of new tendinous tissue existing in this specimen in several situations—in none of which is it probable that the operation had been performed in less than two years previous to death—was opposed to the theory, still advocated by my colleague, Mr. Tamplin and some other orthopædic authorities, of this structure being of a temporary nature, serving only a temporary purpose, and then undergoing contraction and at last complete absorption, so that the divided extremities of the old tendon re-unite, and a linear cicatrix alone remains. In this specimen there can be no doubt that the new tendon was a permanent tissue, and it is important to observe that it existed in considerable quantity in the tendo-Achillis, even though from the repeated operations it may be supposed that re-contraction and relapse of the deformity, had certainly twice occurred. Any adapted shortening of the muscles of the calf therefore, which

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may have taken place, must have been at the expense of the degenerated muscular tissue, and not of the newly-formed tendinous tissue.

Possibly however, the repeated operations were rendered necessary, not so much in consequence of any process of re-contraction, as by an insufficient length of new tendon being obtained after the previous operations; or, by both of these conditions.

The posterior tibial nerve, which was not generally much atrophied or diminished in size through its course down the leg, was suddenly enlarged to about twice its normal size (letter *m*), at a point corresponding to the lower division of the tibialis posticus and flexor longus digitorum tendons. The nature of this enlargement was specially investigated by Dr. G. Harley, of University College Hospital, whose description of the appearances presented is given below, and there can be little doubt that in this case the posterior tibial nerve had been divided.

An irregular distribution of the arteries of the leg, which had been carefully injected in the specimen, existed in this case. The posterior tibial artery was absent—a fortunate circumstance as the nerve had been divided; but the peroneal artery, which occupied its ordinary position (letter *n*), was enlarged to nearly the size of the posterior tibial, and after giving off small branches, crossed the ankle-joint from the fibula towards the inner side of the os calcis—it might be said to wind round the superior and internal surfaces of the os calcis—and from this point, at which it represented the posterior tibial artery (letter *o*) though placed more to the outer side of the leg, and also much to the outer side of the posterior tibial nerve, its distribution in the sole of the foot, with the division into the internal and external plantar arteries was normal.

Mr. Adams, 6*th of January*, 1857.

Microscopical Examination of the Enlargement of the Posterior Tibial Nerve in the above case.

The small tumour, on the posterior tibial nerve, commences at about one inch above the point where the nerve divides into the internal and external plantar branches. It extends upwards

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DESCRIPTION OF PLATE X.

This plate illustrates the Reparative Process after Division of Tendons in Mr. Adams's case of Talipes Equino-varus, p. 393.

a. a. Tendo-Achillis longitudinally divided, exhibiting the extent and relations of the new tendonous material, as follows:—*b. b.* the upper and lower terminations of the old tendon, between which new tendon is seen, intermixed with a small quantity of old tendon, several divisions having been made within this distance. *c.* indicates an isolated portion of old tendon, presenting a white glistening appearance, with new tendon above and below it. *d.* A transverse line apparently indicating where a division had been performed through the new tendon.

e. e. The tibialis posticus tendon longitudinally divided. *f.* a wedge-shaped portion of new tendon, where an imperfect division had been made. On the corresponding half of the tendon in this situation, there is only a trace of new tendon, the old tendonous fibres being distinctly continuous in most parts. *g.* indicates the situation in which this tendon has been divided behind the malleolus; and on same level it will also be seen the flexor longus has also been divided. *h. h.* The upper and lower extremities of the divided posterior tibial tendon. *i.* The anterior wall of the sheath of the posterior tibial tendon which has been laid open, and to which the divided extremities of this tendon are adherent, through the medium of a small quantity of new tendonous tissue, formed in connection with them. *j.* Indicates the new tissue connected with the upper extremity of this tendon.

k. A portion of new tendon, seven-eighths of an inch in length, formed between the divided extremities of the tendon of the flexor longus digitorum muscle, which had evidently been divided above the malleolus simultaneously with the partial division of the posterior tibial tendon in this situation. *l.* A similar portion of new tendon, one inch and an eighth in length, between the divided extremities of the flexor longus tendon, behind the malleolus. This operation had evidently been performed at the same time as the division of the posterior tibial tendon behind the malleolus. Between these two long portions of new tendon, an isolated oat-shaped portion of old tendon is seen.

m. The posterior tibial nerve enlarged to about twice its normal size, probably in consequence of having been divided or wounded when the posterior tibial and long flexor tendons were divided.

n. The peroneal artery occupying its ordinary position but much enlarged, to compensate for the absence of the posterior tibial artery.

o. Continuation of the peroneal artery, winding round the inner side of the os calcis to gain the sole of the foot, and supply the place of the posterior tibial.

p. An accessory muscular slip connected above with the flexor longus pollicis, and by its tendon in the sole of the foot with tendon of the flexor longus digitorum.

q. The tendon of the flexor longus pollicis crossed by the accessory muscle, *p.*

r. The tendon of the tibialis anticus muscle.

s. The plantar fascia.

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for three quarters of an inch, and, at its thickest point, measures seven-eighths of an inch in circumference, which is three-eighths of an inch more than that of the nerve itself. On making a longitudinal section of the tumour, it was easy to follow the course of the nerve-fibres, and they were observed to be, individually, very little thickened, although, collectively, the increase in their diameter was very visible. To the naked eye, the common neurilemma, or vagina cellulosa surrounding the enlargement, appeared to be somewhat more dense than at any other point of the nerve. The same remark is applicable to the sheath or membrane encircling the funiculi.

On examining a portion of the nerve-substance microscopically, the tubular nerve-fibres were found to be well-formed, and shewed very distinctly the normal sinuous outline, and double contours. The nerve-substance was carefully examined throughout the whole length of the tumour, without anything remarkable being discovered, except that here and there, a few of the nerve-fibres were somewhat granular in their interior with the double contours consequently indistinct. This appearance might probably be attributable to the action of the spirit in which the preparation had been kept. The microscope shewed that there was a considerable increase of cellular tissue distributed among the nerve-fibres, and this, with the slight thickening of the neurilemma, constituted, no doubt, the enlargement. As the tumour could not be said to possess any of the characters of an idiopathic neuroma, while, on the other hand, it very much resembled the enlargements found at the point of union of divided nerves, it may, I think, with safety, be ranked among the latter class, especially as the presumptive evidence is in favour of its having been accidentally divided during some of the operations.

Dr. G. Harley.

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5. *Horny Growth from the Lip, associated with Epitheliel Cancer.*

The horn was about an inch and a half long, and hung from the lower lip near the right oral angle of a man, æt. 60. It pretty exactly resembled one shewn by Mr. Henry Gray at a former Session of the Society. It had been growing for about twenty

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years, and had once had its end cut off. The interest of the case, however, attached to the circumstance, is that during the last year a papillary epithelial cancer had developed itself at the base of the horn, and had extended on the inside of the cheek. The part thus involved was about the size of a crown piece and much thickened. There was also an enlarged gland under the jaw. The whole was freely removed by the V shaped incision and the wound healed well. The case afforded an interesting example of the development of cancer on a part long exposed to irritation.

Mr. HUTCHINSON, *3rd of March*, 1857.

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6. *Melanotic Disease of the Great Toe, following a Whitlow of the Nail.*

The peculiar feature in the case which had furnished this specimen was the supervention of undoubted malignant disease upon an ulcer originally of innocent character. M. D., an Irish charwoman, æt. about 60, and in very good health, first presented herself as an out-patient at the Metropolitan Free Hospital in the early part of 1855. She had an ungual whitlow of the right great toe, which had troubled her for about eight months. She said that it had originally been caused by her having worn a boot which pinched her; part of the nail had already come away, and I took away with the scissors a considerable portion more which was quite dead. The matrix of the nail and the adjacent parts were in an inflamed and very irritable state, but there was nothing more than is often seen in this most troublesome form of onychia. She attended irregularly for some months, during which time various forms of ointment were used without any benefit. I was inclined to attribute the indolency of the ulcer to her being obliged to be continually on her feet. Its base gradually got thicker and more swollen, and the idea of there being some syphilitic taint having suggested itself, I made a trial of the iodide of potassium internally, but without any material effect on the sore. At length she grew tired of attending, and I lost sight of her for some months.

In February, 1857, she again presented herself, the condition of things being much worse. The toe was greatly enlarged and

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there were some bossy masses of induration, which, although not definite looked very suspicious. Ulceration of one of these nodosities had taken place a little above the sore left by the removal of the nail. There was no evidence of attempt to reproduce the nail; the sore, on the contrary, was covered by livid and very indolent looking granulations. She now complained that the pain, which had always been considerable, had increased so that it prevented her sleep. It was of a darting, pricking character. On examining her thigh, I found about its middle, just over the vessels a softish mass about the size of a small apple, but more spread out, which was moveable both upon the deeper parts, and in respect to the skin. The degree of hardness of this tumour was closely similar to what I have usually noticed in glands which are the seat of melanotic disease, and curiously enough, the site was the exact one, in which with primary melanosis, on some part of the foot, I have several times seen the first gland enlargement take place. The glands in the groin were not enlarged. There was now little doubt as to the malignant nature of the disease, and it was accordingly determined to remove it. After amputation, the toe shewed a growth of melanotic and medullary cancer infiltrating the subcutaneous tissues about the sore. In some parts the deposit was quite black, whilst in others and larger ones, it was colourless. The glands removed from the thigh were melanotic only, in parts they had softened and contained a thick black fluid.

Both wounds healed soundly. It should have been stated that at the time of the operation the woman had not materially lost flesh and was still in good health.

Mr. Hutchinson, *3rd of March*, 1857.

[Note.—October 25th. The poor woman is now again under care on account of the return of a disease. In the groin is a large bleeding mass of cancer and two small nodules of melanosis exist near the cicatrix of the amputation.—J. H.]

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7. *Case of Talipes Equinus Paralyticus.*

For the opportunity of shewing this preparation to the Society,

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I am indebted to Mr. Nunn, who obtained it from the dissecting-room of the Middlesex Hospital School. It possesses some points of interest, as illustrating the cause of a difficulty that is sometimes met with in paralytic cases of equinus, *viz.*, the inability to flex the foot after the division of the tendo-Achillis. The cause is found to depend, in the first place, on the extreme degree of displacement of the astragalus downwards and forwards, and secondly, on the shortened condition of the bands of ligament that pass down from the posterior part of the tibia and fibula; this shortened condition having taken place owing to the displacement of the astragalus, and so allowing the end of the tibia to be brought to rest upon the upper surface of the os calcis, and to be retained in this position, by these ligamentous bands, and to become the obstacle to the replacement of the astragalus, there being little or no space left between the two former bones.

The deformity was found to be caused, not only by the displaced astragalus, but by the entire bone being approximated to the os calcis by the shortening of the calcaneo cuboid ligament. The astragalus itself was also altered in shape, having its anterior portion or band bent downwards. The level of the os calcis was but little altered, shewing that though the shortened condition of the tendo-Achillis was the original cause of the deformity yet that it was the shortened condition of the ligament I have referred to which had so much to do with its persistence.

Mr. Edward F. Lonsdale, *7th of April*, 1857.

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8. *Curious Case of Malformation of the Lower Extremity from Arrest of Development.*

A boy, æt. 4, was brought to the Royal Orthopædic Hospital, with apparently the absence of the left lower extremity, with the exception of the foot. The foot was attached to the pelvis, close to the ilium. On examining by what means it was connected, it was not easy to discover any well-defined bone, though there evidently was a sunk bone passing upwards towards the acetabulum, and this obscurity was increased, owing to the child being very fat about the buttocks. The foot was well formed, with

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the exception of the absence of the little toe. Fig. 16, illustrates the appearance of the malformation.

Fig. 16.

This case is interesting, as forming a pendant to a case presented to the Society in the year 1852, and which was published in the "Transactions" for that year.

Mr. Edward F. Lonsdale, 21*st of April*, 1857.

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9. *Malformation of the Leg and Foot.—Absence of the Fibula and two outer Toes.*

I have seen eight cases of this kind of malformation, in all of which the same arrest of development existed, *viz.*, the absence of the two outer toes, fusion together of the other three—absence of the fibula—curvature forwards of the tibia at an acute angle, with a peculiar depression or dimple in the skin opposite the angle of the bone, giving the appearance of a cicatrix. In all, the affected leg was shorter than the opposite one, being one, two, and three inches, and in one case, nearly four inches shorter. In all, the shortening was from the

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knee downwards, the thigh being of the length of the opposite side. Mr. Edward F. Lonsdale, 21*st of April*, 1857.

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10. *Cases of Cysticercus Cellulosæ, removed from the Sub-cutaneous Cellular Tissue.*

A healthy boy, æt. 10, was brought to me on account of a little tumour, the size of a hazel nut, beneath the skin of the arm near the insertion of the deltoid. It was loose and moveable, quite painless, and had been known to exist for nearly a year. A small incision was made over it, and having cut through the subcutaneous fat, it was dissected out. It consisted of a thick fibrous cyst in which was a cysticercus, of which the membranous body was nearly an inch long, and attached at one end to the containing cyst. Its head, under the microscope presented a most beautiful object, none of the hooklets having been detached. At the time this case occurred I had never before met with the cysticercus immediately beneath the skin, though I had often seen it in other situations (brain, muscle, eye, &c.,) and had repeatedly found the echinococcus hydatid in the former locality. A few weeks afterwards, however, a young woman came to me for a small nut-like tumour, under the skin of the mammary region, which also on excision proved to be a cysticercus. It is worthy of remark in respect to Siebold's interesting observations, that neither of these patients were known to be subject to tape-worm.

Mr. Hutchinson, *5th of May*, 1857.

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11 *Spontaneous Fracture of Six Bones in a Child, apparently Strumous.*

M. J., æt. 2½, a child with a bloated, dusky look, evidently in great suffering, and lying perfectly helpless, was brought into the out-patient room of Charing Cross Hospital, when the following history of it was given me:—Parents both living and healthy; neither of them had had syphilis; three brothers and sisters, all healthy. The child was born quite healthy, and was always so till about eight or ten months old, when she had some "blind boils" come out on her; one on

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her leg discharged, and was open and running some time: her parents say she must have suffered from these nine or ten months. When she recovered from them she seemed quite well, but looked delicate; she never ran about strong, but crept about by the chairs; she seemed to limp, too, on the side where the boil (abscess?) was; the hip also seemed to project on that side, and the thigh to bow out. She had a habit, too, of pulling her hair out, so as to make it nearly bare in some places, and of knocking her head against anything hard that she could find, as against a chair, the sill of the window, and the floor, so as to bruise it, and make it black and blue, and her mother was often obliged to take her up, to put a stop to it. But the child was very sensible and intelligent, and could talk.

About eight months ago the mother took the child down to Hampshire to see her uncle. With the exception of the boils, which were not quite healed, the child was very well, but, as she looked delicate, her uncle persuaded her mother to leave her behind, thinking the country air might do her good. About four months ago they wrote to the mother, to tell her, that the child was suffering from a breaking out on the head and face, and that they thought she would be a cripple, as she limped so much on the right leg. The only additional information I can get from the mother as to this time is, that the doctor said that the child ought to be sent into a Hospital. Five weeks ago they wrote to say that she was very bad, and must be fetched away as soon as possible, (but did not describe the child's condition;) the mother, however, could not fetch her, as she was puerperal. Then, five or six days ago, they wrote again to say that they did not expect she would live, and two days ago they brought her up to town. She was then in the state that she is now in, and which I will describe, and was so disfigured, especially by the loss of the nose, that her mother would not have recognised her. From the time of its arrival to the present the mother says the child has been uttering the same ceaseless cries that she does now. These cries of the child are peculiarly distressing, and indicated protracted suffering; its expression is at once excited and exhausted, and its manner restless and helpless, its sufferings being increased by movement on the one hand, and

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preventing its resting on the other. I will endeavour to describe the child's appearance.

In the first place, the child has lost its nose, as if by ulceration of the cartilages; the alæ seem partially, and the lower part of the septum quite, eaten away, so that instead of the nose there is a hole occupied by a black scab. This imparts to the countenance the look of the syphilitic face. The lips are covered with sordes, and the tongue and mouth black, and baked up; the child's face looks bloated, and almost discoloured; its hair is nearly all torn out. The left hand lies perfectly helpless by its side, and in a very peculiar position, and the reason of this, on exposing the arm, is at once shewn—the humerus is broken, and bent at a right angle, and the arm loose and hanging; below the point of fracture the arm is twisted, so that the whole arm as well as hand is prone, and the olecranon, instead of the elbow, lies upwards. On drawing down the hand, and so straightening the arm, the child immediately (though evidently with great suffering) raises again the upper segment of the humerus at right angles to its body, from which the lower half of the humerus, and the rest of the arm, hangs at a right angle to it, so that it looks as if the elbow-joint were almost up to the shoulder. On making the arm supine, I saw that at the bend of the elbow there was a round hole, as big as a pea, from which stinking watery pus was running. I found also that the pieces of the humerus were perfectly loose, and that the arm might be loosely bent about almost in any direction, the movement being accompanied by crepitation, not, however, like the dry bony crepitation of ordinary fracture, but a loose crackling: the arm and hand were tight, dark, and shining. On examining the other limbs, I found them all more or less bent—the right forearm, the thighs and legs, the bones were flexible, but none apparently broken; the thighs, legs, and feet, were tumid and shining, of a dusky-colour, and looked as if they would burst, like the early shining swelling of an abscess; on the soles of the feet there were black blisters. The skin and cartilages of both ears were ulcerated in the same way as the nose, the tragus and antitragus and the lower wall of the outer part of the external

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meatus being eaten away; the ulcerous surface is dark and dry. In several parts of the body are rupious-looking scabs. The mother tells me that on moving the child's left arm to-day to wash it, as much as half a teacupful of matter ran out of the hole at the bend of the elbow. There is nothing amiss in the sounds of the child's chest; its breathing is short and panting, but it is the dyspnœa of pain. It appears to have no pain or tenderness in its abdomen. The child's bowels are regular, but it has no appetite, and only calls for tea.

I endeavoured to obtain its immediate admission into the Hospital, but was unable from the fulness of the beds. I ordered the child a mixture containing ammonia and ether, and a teaspoonful of cod liver oil with a little syrup of iodide of iron three times a day. I saw it the next day, Saturday, it was just in the same state; it had had no sleep and had not ceased its cries. It seemed to be more feeble; the arm continued to discharge. The parents came to me that evening to say that soon after I left, the child quietly died, and I made the *post-mortem* examination on Monday morning, thirty-six hours after death.

Post-mortem.—On examining the limbs, Plate XI, I found that the left humerus was not the only bone broken; but that the right femur, the left tibia and fibula, and the right radius and ulna were also broken. The limbs could be bent, at the point of fracture, in any direction, and gave a sense of loose crackling. The points of fracture, with the exception of the humerus, from which the discharge was still running, were the seat of tense and hard swelling, and in the right femur distinct fluctuation could be detected. On cutting deeply into these points, thin, watery, rather discoloured pus escaped from them; and on making a more complete dissection it was found that in each case the extremities of the fractured bones were embedded loose in pus. The matter that escaped from the right thigh must have been from an ounce to two ounces, in the other cases only a drachm or two. The hole at the bend of the left elbow, from which the matter had been some time escaping, was found to communicate with an abscess embedding the broken end of the humerus and to have no connexion with the joint.

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On more particularly examining the fracture above the left elbow it was found to consist essentially in the separation of the epiphysis from the shaft of the bone, the surfaces being sinuous and exactly fitting into each other, and marking the extent to which ossification had proceeded. There was no cartilage on either surface; the bare cancellous structure was exposed. The shaft of the bone, for about an inch, and the epiphysis, for about a quarter of an inch, were denuded of their periosteum, between which and the bone the puriform matter lay, so that the matter was in this case sub-periosteal: extending up from the broken extremity on one side, for about one-third of an inch, the compact tissue of the shaft appeared ulcerated away, exposing the cancellous structure. The fracture of the femur was oblique across the centre of it. The lower segment, for about an inch, was bare of periosteum, the upper not, but covered by what appeared to be periosteum thickened by plastic exudation. The walls of the pus-containing cavity in which the extremities of the bone were embedded were very thick and of almost cartilaginous hardness. The thickness and strength of the bones generally seemed hardly such as the age of the child would warrant, and the bone-structure in the immediate neighbourhood of the fractures seemed unduly cancellous, and too easily cut with a scalpel. There was, however, nothing like mollities; the bones were perfectly hard and unbendable. At the fractured extremities the ordinary medullary matter was supplanted by what appeared to be plastic exudation, thrown out probably by the medullary membrane.

All the viscera were healthy.

Several questions suggest themselves to one's mind as to the nature of this case—Was there any syphilis in it? Was it strumous? Were the fractures from violence? How long had the condition of the bones existed? There seems not the slightest reason for suspecting syphilis; the parents were married young, appeared respectable, truthful, and attached to one another. The possibility of violence is denied by those with whom the child was, and indeed the condition and seat of the fractures was not such as to suggest violence. Moreover, the progress of the mischief appeared quite gradual. I have no doubt that the

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DESCRIPTION OF PLATE XI.

The figure, from a sketch made shortly after death, illustrates Dr. Hyde Salter's case of Spontaneous Fracture of Bones, p. 408.

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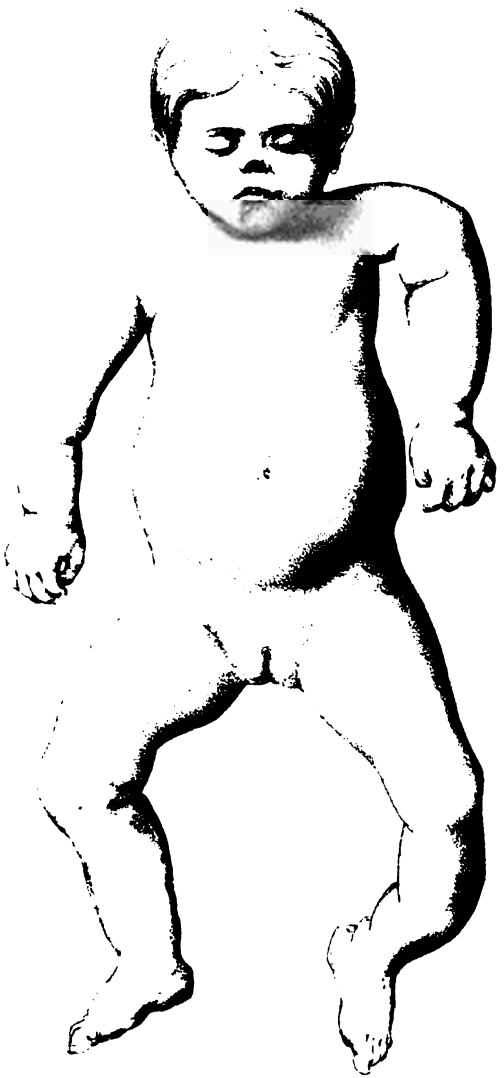

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disease of the right femur had commenced when the child was eighteen months old and it was remarked that she limped on the right leg, and that the right thigh bowed out, which was a twelvemonth before her death. I am inclined to believe that the case was essentially strumous; that the fractures were spontaneous; that they depended on a degree of friability at the parts fractured that did not exist elsewhere; that this friability was due to strumous infiltration at the point fo fracture, and that the suppurative process was secondary to the strumous; it seems clearly to have begun *in* the bone as the periosteum was external to the pus. I regret that this puriform matter and the extremities of the bones were not examined when they were sufficiently recent to ascertain if they were impregnated with material distinctly strumous. The child had a decidedly strumous aspect although there was no clear history of struma in the parents. Dr. SALTER.

XI. SPECIMENS FROM THE LOWER ANIMALS.

1. *Hydatid Cyst in the Eye of a Horse.*

The eye was that of an old pony who had been totally blind in both eyes for many years before his death. It was sent me for examination from Green Hammerton, near York, by my friend Mr. J. H. Jackson, and was in a perfectly fresh state when it came to hand.

The cornea was quite opaque, thickened, and leathery. The globe had its natural contour and shape, there being no staphyloma. On making a vertical section of the globe, the following condition was found. The vitreous humour was converted into an opaque brownish-fluid and readily ran out. The retina and choroid were detached and hung loosely in folds. The lens was opaque, of amber yellow, and quite loose in its thickened and opaque capsule. The iris was so much disorganised by inflammation, and by the pressure upon it of other structures about to be described, that its proper texture was scarcely to be detected. Occupying the whole anterior chamber was a sac formed by a thick corrugated membrane,

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which was firmly attached all round by an angular duplication at the margin of junction between the iris and the sclerotic. This membrane adapted itself accurately to the concave surface of the cornea, completely lining the anterior chamber, and, passing through the pupil, it was reflected on the posterior surface of what remained of the iris, and thence on to the capsule of the lens. It was very tough, and, in parts, had a thickness of a line or more. Enclosed within it, and adhering at parts inseparably to it, was an hydatid cyst, which consisted of two most delicate and beautifully translucent lamellæ, in which floated a body resembling a cysticercus. The cysticercus itself had loose attachments to its containing cyst. On careful examination with the microscope, the cyst-membrane did not shew in any part the concentric arrangement of lamellæ so characteristic of the echinococcus cyst wall, but appeared to be composed of delicately fibrillated albuminous material. I was not fortunate enough to light upon the head of the animal, or to find any of its detached hooklets. There could, however, I think, be no reasonable doubt, from the naked eye appearance of the cyst walls, that it was really a specimen of the cysticercus hydatid. The destruction of the eye had, in all probability, been consequent on its presence. As to whether the enclosing tough fibrous membrane above described as lining the two chambers, should be regarded as an organized false membrane, the result of inflammation, or whether it were a "thickened membrane of the aqueous humour," opinions will probably differ. Each supposition has certain facts in its favour. It appears to me very improbable that a false membrane should adapt itself accurately to the chambers which it lined, and adhere firmly in those parts only in which a normal anatomical structure might be expected to be united. On the other hand, it must be admitted that the eye had been the seat of long continued inflammation, from which it is quite possible such a membrane might have resulted, whilst it is, perhaps, unfair to assume the existence in a morbid specimen, of a structure which cannot be demonstrated in the healthy state.

Mr. Hutchinson, 16*th of December*, 1856.

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2. *The Nematoideum Natricis* (Creplin).—*An Entozoon found in the Lung and Intestine of the Common Coluber.*

Though comparative anatomy is not one of the branches of science to which this Society professes to devote itself, the subject of helminthology, as studied in the lower animals, is so intimately connected with the elucidation of the nature of human entozoa, that I have taken the liberty of shewing a few specimens of a worm which I found a few days since. I was assisting Dr. Quain in dissecting the vascular system of the common snake, and, on examining the air-cells of the lungs under the microscope, I found them filled with the ova and young of an entozoon, some of which I exhibit to the Society. Most of the air-cells contained these parasites, and, in the large breathing cavity, I detected four adult female specimens, which I have also laid before the meeting. The only other part of the snake in which I could find this animal was the lower intestine, where there were a large number of ova and young.

This entozoon is the more interesting as it has never been fully described by writers on the subject; Rudolphi, Diesing, and others, taking their notice of what appears to be the same species, from an imperfect description by Dr. Creplin in Muller's archives. Although I have not been able to satisfy myself on several points in its anatomy, the following may be accepted as a general description of it.

The adult females are about one-sixth of an inch in length, and $\frac{1}{170}$th of an inch in breadth; and the ova are about $\frac{1}{400}$th of an inch in length. The female, to which this description must apply in all which regards the adult form, *vide* Plate, is nearly the same breadth throughout, except at the head, where it tapers slightly towards the mouth, and at the tail, where it tapers to a sharp point. There do not appear to be any suckers or similar apparatus, at the cephalic extremity, the lips being simple induplicatures of the investing membrane. The alimentary canal consists of an œsophagus and intestine. The œsophagus is a strong muscular pouch, which becomes wider as it recedes from the mouth, and forms about one-twentieth of the whole canal; it communicates with the intestine by a small, but dilatable opening, Plate VIII. Fig. 8. Fig.

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8 *a*, and Fig. 10. *a*. The intestine occupies the greater part of the interior of the animal, extending from the œsophagus to the tail, near which it opens by a small anal aperture. I could not detect any muscular structure in its walls. The nervous system consists of two cords, running from one extremity to the other, but whether gangliated or not I could not discover, Fig 9. *e*.; some brown coloured spots scattered along their course, did not appear to be peculiar to that part of the structure, neither could I detect any loops encircling any of the organs. Some obscure markings under the integument may be analogous to what has been described as the circulatory system of these animals; they were the only traces of such a structure which I was able to find. The uterus is large and occupies about one-sixth of the body, being situated rather nearer the tail than the head, Fig. 8. *c*.; and in the specimens which I examined, are filled with ova. In one of the individuals there was a protrusion, situated in the integument, about half-way between the head and tail, to which I thought I could trace a communication with the uterus. This would therefore be regarded as the vagina; and as its position is similar to that of the same organ in most of the species whose anatomy has been more completely elucidated, strong probability is given to the supposition. The ova existed in every stage of development, from the commencement till the period just preceding the formation of the young worm; those in the last stage are not contained in the uterus as the process is completed outside the animal. The degree of development represented in Fig. 11. *h*, shews the stage to which the ova arrive before their expulsion from the womb of the parent; the stage from *h* to *i* is found floating in the mucus of the lung, or intestine of the snake, along with large numbers of the newly-born young, such as is represented at Figure 11. *k*.

It is interesting to observe the similarity between the encysted or embryoric form of this worm as represented in Figure 11. *i*, and the trichina spiralis found in the muscle of higher animals; and this seems to favour the supposition that the trichina is the embryonic form of some more highly organized entozoon, requiring to be transplanted to a different nidus to permit of further development; nor does the fact that the trichina is a more

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perfectly organised worm than the encysted form of the other Cœlelminthæ militate powerfully against such an idea.

Dr. Quain for Dr. Sibbald, *5th of March*, 1857.

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3. *Two Specimens of Cysticercus Fasciolaris, from the Liver of the Mouse.*

One was about an inch and a half in length, gradually tapering from the anterior to the posterior extremity, in which latter situation was a terminal cyst about the size of a pea. With this specimen was the cyst on the under aspect of the liver, from which the animal had been removed. The other specimen was a much larger one, being between six and seven inches in length. It had the same form as the other; the segmentation, however, was much more distinct, and the terminal cyst somewhat smaller. These were not brought forward on account of their rarity, but on account of the unusual size to which the larger animal had attained, whilst in its encysted condition. It only differed from the tænia of the cat, in the absence of generative pores, and in the presence of a terminal cyst.

Dr. Sydney Jones, *17th of March*, 1857.

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